Section 1915(b)(3) Waiver
Proposal For
Missouri's MCO and PCCM (ToRCH) Programs

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Proposal for a Section 1915(b)(3) Waiver
MCO and PCCM (ToRCH) Programs

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of **Missouri** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **names of the waiver programs** are the MO HealthNet Managed Care Program and the Transformation of Rural Community Health (ToRCH) Program. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

___ Initial request for new waiver. All sections are filled.

_X_ Amendment request for existing waiver, which modifies Section/Part:

- **Appendix D1 – Member Months**
- **Appendix D4 – Conversion or Renewal Waiver Cost Projection and Adjustments**
- **Appendix D5 – Waiver Cost Projection**
- **Appendix D7 – Summary**

___ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

___ Document is replaced in full, with changes highlighted

___ Renewal request

___ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

_X_ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is

___ replaced in full

_X_ carried over from the previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

_X_ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is

____ replaced in full

__X__ carried over from the previous waiver period. The State:

__X__ assures there are no changes in the Monitoring Plan from the previous waiver period.

____ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages.

Effective Dates: This waiver/renewal/**amendment** is requested for a period, effective January 1, 2026, and ending June 30, 2029. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The state contact person for this waiver is Kathryn Dinwiddie and can be reached by telephone at (573) 526-4274, or fax at (573) 526-3946, or e-mail at Kathryn.M.Dinwiddie@dss.mo.gov. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

RESPONSE:

There is one (1) federally-recognized Urban Indian Organization in Missouri, and there are no federally-recognized tribes in the State. The State implements applicable federal protections for American Indians/Alaskan Natives (AI/AN), including but not limited to those required by Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA). The state assures that the premium and cost-sharing protections under Section 5006 of the ARRA are provided in accordance with 42 CFR 447.56, as well as the managed care protections under 42 CFR 438.14. Missouri will extend implementation of the AI/AN protections to all Indians to whom the federal protections apply, including;

- Informing the Managed Care Organizations (MCOs) of this requirement, including payments to the Urban Indian Health Program (ITU) facilities; and
- Sending notice to all individuals who are identified as AI/AN, informing them that the plan must allow them to seek access through ITUs.

Missouri understands that AI/AN members are entitled to receive services from Indian Health Care Providers out of state. Missouri will send notices to all individuals who are identified as AI/AN, informing them of their right to seek care from Indian Health Care Providers.

Missouri provides the federally recognized Urban Indian Organization with a summary of the matter and changes made, with the opportunity for them to make comments.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

RESPONSE:

MO HealthNet Managed Care Program

In 1995, Missouri requested and received approval to implement a managed care program, MO HealthNet Managed Care, in the Eastern Region of the State. Waiver authority was granted under Section 1915(b) of the Social Security Act for managed care organizations (MCOs) to provide contracted services to certain targeted groups of Medicaid eligibles. The mandatory target groups included MO HealthNet for Families (MHF), formerly known as Temporary Assistance for Needy Families (TANF), MO HealthNet for Pregnant Women and Newborns, formerly known as Medicaid for Pregnant Women (MPW), MO HealthNet for Kids (MHK), formerly known as Medicaid for Children, and children in state care and custody. MO HealthNet participants in the targeted groups who receive Supplemental Security Income (SSI) or who meet the medical definition of "permanently and totally disabled" for SSI may choose not to enroll or may voluntarily disenroll from the MO HealthNet Managed Care Program at any time.

During December 2001, uninsured custodial parents with incomes below 100% of the federal poverty level were transitioned to coverage in the Managed Care Program under Section 1931 of the Social Security Act, effective January 1, 2002. Between 2002 and 2005, budget actions lowered the eligibility standards, and coverage ended for this group of uninsured parents.

Effective July 1, 2007, individuals who are independent foster care adolescents, age 18 to 21, are eligible for coverage without regard to income or assets. These individuals have the opportunity to enroll in a MO HealthNet Managed Care health plan in areas of the state served by the MO HealthNet Managed Care Program. In areas of the state where MO HealthNet MCOs are not operational, these individuals receive benefits from the MO HealthNet Fee-For-Service Program. These individuals receive all services specified in the comprehensive benefit package for children in state care and custody, less than 21 years of age. This change extended coverage to about 970 individuals. Approximately 175 individuals were eligible for coverage under the MO HealthNet Managed Care Program.

On September 1, 2007, the medical assistance program on behalf of needy persons became known as MO HealthNet and the title "Division of Medical Services" became the MO HealthNet Division (MHD). Medicaid shall also mean MO HealthNet.

Effective August 28, 2013, individuals who are independent foster care adolescents, ages 21 through 25, are eligible for coverage without regard to income or assets. These individuals receive the services specified in the comprehensive benefit package for children in state care and custody, less than 21 years of age, to include Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings. All services for these individuals were funded through General Revenue (state only) funds for the period August 28, 2013, through December 31, 2013. These individuals have the opportunity to enroll in a MO HealthNet Managed Care health plan in areas of the state served by the MO HealthNet Managed Care Program. In areas of the state where MO HealthNet Managed Care MCOs are not operational, these individuals receive benefits from the MO HealthNet Fee-for-Service Program. This change extended coverage to approximately 2,655 individuals.

Effective January 1, 2014, individuals who are independent foster care adolescents, ages 21 through 25, began providing a comprehensive benefit package for children in state care and custody but EPSDT screening and EPSDT services not covered by the Medicaid State Plan will be excluded.

Effective January 1, 2016, the Show-Me Healthy Babies Program for individuals who are targeted low-income pregnant women and unborn children began providing a benefit package of essential, medically necessary health services identical to the MO HealthNet for Pregnant Women benefit package. These individuals enrolled in a MO HealthNet Managed Care health plan in areas of the state served by the MO HealthNet Managed Care Program. In areas of the state where MO HealthNet Managed Care health plans were not operational, these individuals will receive benefits from the MO HealthNet Fee-for-Service Program.

Effective May 1, 2017, the State of Missouri extended Managed Care statewide for the managed care eligibility groups already covered. The state was divided into four regions for purposes of the program: the existing Eastern and Western regions, an extended Central region and a new Southwestern region. Three MCOs provided services in all managed care regions: Missouri Care, Inc. (hereinafter may also be known as Healthy Blue (HB)), United Healthcare Community Plan (hereinafter may also be known as United Healthcare (UHC)), and Home State Health (hereinafter may also be known as Home State (HSH)).

The state was awarded the Certified Community Behavioral Health Clinics (CCBHCs) grant from SAMHSA on December 21, 2016. On August 6, 2019, the Sustaining Excellence in Medicaid Act of 2019 (SEMA) Public Law 116-39 was signed into law, which extended the section 223 demonstration from July 15, 2019, to May 22, 2020. All CCBHC services are claimed under the 223 demonstration authority effective July 1, 2023.

Effective October 1, 2021, Medicaid State Plan Amendment (SPA) (MO) 21-0037 provides authority to enroll the new Adult Expansion Group (AEG), qualified adults ages 19-64, into managed care and to provide services through the managed care program.

Effective July 1, 2022, Missouri's Managed Care Program has two (2) delivery systems, a General Plan and a Specialty Plan. The General Plan is awarded to three MCOs, and the Specialty Plan is awarded to one of the same three MCOs awarded a contract for the General Plan. The General Plan encompasses the general managed care eligible population and includes three plan options, while the Specialty Plan includes a specific managed care eligible population and is a single plan option. The awardees of the General Plan and the awardees of the Specialty Plan are to be determined upon award of contracts.

Eastern Region: Beginning in September 1995, the following seven MCOs served approximately 150,000 enrollees: HealthCare USA, Care Partners, Mercy MCOs, Community Care Plus, Prudential Health Care, Humana, and GenCare. The Eastern

Region included the counties of St. Louis, St. Charles, Jefferson, and Franklin and St. Louis City.

Two of the original MCOs (GenCare and Humana) withdrew in 1997. As of December 1999, there were approximately 140,000 enrollees being served by the five remaining MCOs in the same geographic area. On February 1, 2000, HealthCare USA purchased Prudential's Medicaid business. Prudential enrollees were given an opportunity to choose a participating MCO other than Prudential.

On December 1, 2000, the counties of Lincoln, St. Francois, Ste. Genevieve, Warren, and Washington were included in the Eastern Region. The following changes were made to the benefit package: Developmentally Disabled (DD) participants and participants with Third Party Liability (TPL) were no longer carved out; any adoption subsidy child could opt out; reinsurance was excluded; and the 30/20 limitation on mental health services was eliminated. Total enrollment for the Eastern Region at the end of calendar year (CY) 2000 was 155,480.

Care Partners chose not to rebid their contract, which terminated on December 31, 2002. The following MCOs served MO HealthNet Managed Care enrollees in the Eastern Region until June 30, 2006: Community CarePlus, HealthCare USA, and Mercy MC+. Total enrollment for the Eastern Region at the end of CY 2005 was 204,779.

On July 1, 2006, Community CarePlus' ownership changed to include Mercy MCOs. Mercy MC+ was eliminated, and Community CarePlus became known as Mercy CarePlus.

On January 1, 2008, the State of Missouri introduced the MO HealthNet Managed Care Program in Madison, Perry, and Pike counties. These three counties were included in the current Eastern Region. Approximately 4,745 individuals enrolled in the MO HealthNet Managed Care Program in the Eastern Regions as a result of the expansion. On October 1, 2008, Mercy CarePlus was renamed Molina Healthcare of Missouri. Total enrollment for the Eastern Region at the end of CY 2009 was 184,932.

The following MCOs served MO HealthNet Managed Care enrollees in the Eastern Region until June 30, 2012: Harmony Health Plan of Missouri, HealthCare USA, Missouri Care Health Plan, and Molina Healthcare of Missouri. Total enrollment for the Eastern Region at the end of CY 2011 was 209,344.

On July 1, 2012, the following MCOs served MO HealthNet Managed Care enrollees in the Eastern Region: HealthCare USA, Home State Health Plan, and Missouri Care Health Plan. Total enrollment for the Eastern Region at the end of CY 2013 was 196,303.

On July 1, 2015, the following MCOs served MO HealthNet Managed Care enrollees in the Eastern Region: Aetna Better Health of Missouri, Home State Health Plan, and Missouri Care Health Plan. Total enrollment for the Eastern Region at the end of CY 2015 was 205,253.

On May 1, 2017, the following MCOs began serving MO HealthNet Managed Care enrollees in the Eastern Region: Missouri Care, United Healthcare Community Plan, and Home State Health. The total enrollment for the Eastern Region at the end of calendar year 2017 was 232,337.

The total enrollment for the Eastern Region at the end of calendar year 2019 was 186,621, and the MCOs that serve the Eastern Region are Missouri Care, United Healthcare Community Plan, and Home State Health.

Effective July 1, 2022, the following MCOs serve MO HealthNet Managed Care enrollees for the General Plan in the Eastern Region: Missouri Care, Inc. D/B/A Healthy Blue, United Healthcare of the Midwest, Inc. and Home State Health Plan, Inc.. The MCO that serves MO HealthNet Managed Care enrollees for the Specialty Plan in the Eastern Region is Home State Health Plan, Inc.. The total enrollment for the Eastern Region at the end of the calendar year 2022 was 370,024.

Central Region: Missouri received waiver modification approval to expand the MO HealthNet Managed Care Program to the Central Region in March 1996. Three MCOs (HealthCare USA, GenCare, and Blue Choice) served approximately 31,000 enrollees in the following eighteen counties: Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Randolph, and Saline. In February 1998, GenCare and Blue Choice were no longer participating MCOs. They chose not to rebid their contracts. Effective March 1, 1998, the participating MCOs were Care Partners, HealthCare USA, and Missouri Care. There was no change in the counties served. At the end of CY 2000, a total of 36,871 participants were enrolled. Contracts were rebid effective March 1, 2001. Participating MCOs were Missouri Care and HealthCare USA. Care Partners chose not to rebid their contract. The following changes were made to the benefit package: DD participants were no longer carved out; any adoption subsidy child could opt out; reinsurance was offered through the state, but MCOs opted to purchase from an outside entity; and the 30/20 limitation on the mental health services was eliminated.

The following MCOs served MO HealthNet Managed Care enrollees in the Central Region until June 30, 2006: Community CarePlus, HealthCare USA and Missouri Care. Total enrollment for the Central Region at the end of CY 2005 was 55,636. Effective July 1, 2006, Community CarePlus' ownership changed to include Mercy MCOs. Mercy MC+ was eliminated, and Community CarePlus became known as Mercy CarePlus. Total enrollment for the Central Region at the end of CY 2007 was 50,159.

On January 1, 2008, the State of Missouri introduced the MO HealthNet Managed Care Program in Benton, Laclede, Linn, Macon, Maries, Marion, Phelps, Pulaski, Ralls, and Shelby counties. These ten counties were included in the current Central Region. Approximately 23,636 individuals enrolled in the MO HealthNet Managed Care Program as a result of the expansion in the Central Region. Effective October 1, 2008, Mercy

CarePlus was renamed Molina Healthcare of Missouri. Total enrollment for the Central Region at the end of CY 2009 was 70,857.

The following MCOs served MO HealthNet Managed Care enrollees in the Central Region until June 30, 2012: HealthCare USA, Molina Healthcare of Missouri, and Missouri Care Health Plan. Total enrollment for the Central Region at the end of CY 2011 was 81,523.

On July 1, 2012, the following MCOs serve MO HealthNet Managed Care enrollees in the Central Region: HealthCare USA, Home State Health Plan, and Missouri Care. Total enrollment for the Central Region at the end of CY 2013 was 77,313.

On July 1, 2015, the following MCOs serve MO HealthNet Managed Care enrollees in the Central Region: Aetna Better Health of Missouri, Home State Health Plan, and Missouri Care Health Plan. Total enrollment for the Central Region at the end of CY 2015 was 81,203.

On May 1, 2017, the State of Missouri extended the Central Region to include the following counties: Adair, Andrew, Atchison, Audrain, Benton, Bollinger, Boone, Buchanan, Butler, Caldwell, Callaway, Camden, Cape Girardeau, Carroll, Carter, Chariton, Clark, Clinton, Cole, Cooper, Crawford, Daviess, DeKalb, Dent, Dunklin, Gasconade, Gentry, Grundy, Harrison, Holt, Howard, Iron, Knox, Laclede, Lewis, Linn, Livingston, Macon, Maries, Marion, Mercer, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Nodaway, Osage, Pemiscot, Pettis, Phelps, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Saline, Schuyler, Scotland, Scott, Shelby, Stoddard, Sullivan, Wayne, and Worth. The following MCOs will serve this region: Missouri Care, United Healthcare Community Plan, and Home State Health. The total enrollment for the Central Region at the end of the calendar year 2017 was 191,771.

The total enrollment for the Central Region at the end of calendar year 2019 was 158,237, and the MCOs that serve the Central Region are Missouri Care, United Healthcare Community Plan, and Home State Health.

Effective July 1, 2022, the following MCOs serve MO HealthNet Managed Care enrollees for the General Plan in the Central Region: Missouri Care, Inc. DBA Healthy Blue, United Healthcare of the Midwest, Inc. and Home State Health Plan, Inc.. The MCO that serves MO HealthNet Managed Care enrollees for the Specialty Plan in the Central Region is Home State Health Plan, Inc.. The total enrollment for the Central Region at the end of the calendar year 2022 was 305,496.

Medicaid Managed Care for AFDC Participants (Jackson County Only)

In July 1982, Missouri received a four-year federal demonstration grant to implement a managed health care program for Aid to Families with Dependent Children (AFDC) participants in Jackson County. Enrollment into the program began in January 1984, with full enrollment achieved in the first quarter of 1985. The original demonstration grant was

extended to December 31, 1986, at which time the established program began operating under a waiver issued by the authority of Section 1915(b) of the Social Security Act, and enrollment was mandatory. The goal of the program was to furnish improved quality, continuity, and accessibility of health care services to enrollees, while providing the state with significant cost savings.

This Managed Health Care Program was a health care delivery system for AFDC participants where primary care services were provided by four prepaid MCOs and approximately thirty individual physicians, called physician sponsors. The four prepaid MCOs were reimbursed on a capitated basis, and the physician sponsors were reimbursed on a Fee-for-Service basis. Each AFDC participant chose either a health plan or a physician sponsor, who was responsible for coordinating the health care provided to the participant. Medical services offered under the Missouri Medicaid Program were also available to managed health care enrollees; however, the majority of these services were either obtained through, or referred by, the chosen health plan or physician sponsor.

Western and Northwestern Regions

An additional waiver modification was requested and approved to expand the MO HealthNet Managed Care Program to the Western and Northwestern regions of the state in January 1997. This expansion replaced the Medicaid Managed Care Program for AFDC participants in Jackson County, which was implemented in January 1984.

Western Region: The Western Region originally consisted of Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray counties. Participating MCOs were HealthNet, Family Health Partners, FirstGuard, and Blue Advantage Plus and served approximately 73,000 enrollees. In February 1999, the service area was expanded to include Henry and St. Clair counties, with the MCOs remaining the same. The DD population was included as an eligible group. Reinsurance was no longer offered as an option, and MCOs were required to purchase reinsurance from an outside entity. Total enrollment for the Western Region at the end of CY 2000 was 83,229.

MO HealthNet chose not to rebid its Managed Care contract, which terminated January 31, 2002. The following MCOs served MO HealthNet Managed Care enrollees in the Western Region: Blue-Advantage Plus of Kansas City, Family Health Partners, FirstGuard Health Plan, and HealthCare USA. Total enrollment for the Western Region at the end of CY 2002 was 126,722.

On July 1, 2006, Community CarePlus' ownership changed to include Mercy MCOs. Mercy MC+ was eliminated, and Community CarePlus became known as Mercy CarePlus. The following MCOs served the MO HealthNet Managed Care enrollees in the Western Region: Blue-Advantage Plus of Kansas City, Children's Mercy Family Health Partners, FirstGuard Health Plan, and HealthCare USA. Total enrollment for the Western Region at the end of CY 2006 was 110,654.

On February 1, 2007, HealthCare USA purchased FirstGuard Health Plan's Medicaid business.

On January 1, 2008, the State of Missouri introduced the MO HealthNet Managed Care Program in Bates, Cedar, Polk, and Vernon counties. These four counties were included in the Western Region. As a result of the expansion in the Western Region, approximately 9,200 individuals enrolled in the program. Effective October 1, 2008, Mercy CarePlus was renamed Molina Healthcare of Missouri.

Blue-Advantage Plus of Kansas City chose not to bid in the four expansion counties and served MO HealthNet Managed Care enrollees in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, and St. Clair counties.

The following MCOs served MO HealthNet Managed Care enrollees in the Western Region in CY 2009: Blue-Advantage Plus of Kansas City, Children's Mercy Family Health Partners, HealthCare USA, Molina Healthcare of Missouri, and Missouri Care Health Plan. Total enrollment for the Western Region at the end of CY 2009 was 120,882.

On February 1, 2012, HealthCare USA purchased Children's Mercy Family Health Partners' book of business.

The following MCOs served MO HealthNet Managed Care enrollees in the Western Region until June 30, 2012: Blue-Advantage Plus of Kansas City, HealthCare USA, Molina Healthcare of Missouri, and Missouri Care Health Plan. Total enrollment for the Western Region at the end of CY 2011 was 137,317.

Effective July 1, 2012, the following MCOs served MO HealthNet Managed Care enrollees in the Western Region: HealthCare USA, Home State Health Plan, and Missouri Care. Total enrollment for the Western Region at the end of CY 2013 was 128,391.

On July 1, 2015, the following MCOs served MO HealthNet Managed Care enrollees in the Western Region: Aetna Better Health of Missouri, Home State Health Plan, and Missouri Care Health Plan. Total enrollment for the Western Region at the end of CY 2015 was 133,987.

On May 1, 2017, the following MCOs began serving MO HealthNet Managed Care enrollees in the Western Region: Missouri Care, United Healthcare Community Plan, and Home State Health. The total enrollment for the Western Region at the end of calendar year 2017 was 160,494.

The total enrollment for the Western Region at the end of calendar year 2019 was 126,839, and the MCOs that serve the Western Region are Missouri Care, United Healthcare Community Plan, and Home State Health.

Effective July 1, 2022, the following MCOs serve MO HealthNet Managed Care enrollees for the General Plan in the Western Region: Missouri Care, Inc., DBA Healthy Blue, United Healthcare of the Midwest, Inc. and Home State Health Plan, Inc.. The MCO that serves MO HealthNet Managed Care enrollees for the Specialty Plan in the Western Region is Home State Health Plan, Inc.. The total enrollment for the Western Region at the end of calendar year 2022 was 259,822.

Northwestern Region: The Northwestern region was composed of Andrew, Atchison, Buchanan, Caldwell, Carroll, Clinton, Davies, DeKalb, Gentry, Grundy, Harrison, Holt, Livingston, Mercer, Nodaway, and Worth counties. Blue Advantage Plus and Community Health Plan served approximately 15,000 enrollees. The two MCOs chose not to contract with the state, and all enrollees reverted to Fee-for-Service on December 1, 1998.

Southwestern Region: On May 1, 2017, a new Southwestern Region was established to include the following counties: Barry, Barton, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Lawrence, McDonald, Newton, Oregon, Ozark, Shannon, Stone, Taney, Texas, Webster and Wright counties. The following MCOs served this region: Missouri Care, United Healthcare Community Plan, and Home State Health. The total enrollment for the Southwestern Region at the end of calendar year 2017 was 130,518.

The total enrollment for the Southwest Region at the end of calendar year 2019 was 109,786, and the MCOs that serve the Southwest Region are Missouri Care, United Healthcare Community Plan, and Home State Health.

Effective July 1, 2022, the following MCOs serve MO HealthNet Managed Care enrollees for the General Plan in the Southwestern Region: Missouri Care, Inc., DBA Healthy Blue, United Healthcare of the Midwest, Inc. and Home State Health Plan, Inc.. The MCO that serves MO HealthNet Managed Care enrollees for the Specialty Plan in the Southwestern Region is Home State Health Plan, Inc. The total enrollment for the Southwestern Region at the end of calendar year 2022 was 221,663.

Benefits and Services: In MO HealthNet Managed Care, enrollees eligible under the 1915(b) Waiver receive the same scope of services that the Fee-for-Service Program offers. Most services are included in the monthly capitation paid to the MCOs. Examples of services include hospital, physician, emergency medical services, EPSDT services, family planning services, dental, optical, audiology, personal care, and some behavioral health services. Certain services are provided on a Fee-for-Service basis outside of the capitation rate such as pharmacy; transplants; physical, occupational, and speech therapy for children if included in an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP); Department of Health and Senior Services (DHSS) testing services (tests on newborns and blood lead testing); and certain behavioral health services. A complete list of benefits and exceptions is detailed within this waiver application.

Effective July 1, 2002, the following changes to the MO HealthNet Managed Care Program resulted from the passage of House Bill 1111 during Missouri's 91st General Assembly legislative session:

- Dental services for participants age 21 and over were limited to the treatment of trauma to the mouth or teeth as a result of injury and dentures.
- Eyeglasses for adults only following cataract surgery, and
- Coverage for circumcisions was limited to medical necessity only.

Coverage of dental services for participants age 21 and over that were eliminated was restored for adults on August 21, 2002, and coverage of prescription eyeglasses for MO HealthNet eligible adults was restored effective February 24, 2003, as a result of preliminary injunction court orders and was covered by the MO HealthNet Fee-for-Service Program.

Effective September 1, 2005, the following changes to the MO HealthNet Managed Care Program occurred as a result of the passage of Senate Bill 539 during Missouri's 93rd General Assembly legislative session:

- Dental services for participants age 21 and over (except for pregnant women in ME codes 18, 43, 44, 45, and 61) were limited to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury. Services for the treatment of a medical condition without which the health of the participant would be adversely affected were carved out of the MO HealthNet managed care comprehensive benefit package and covered through the MO HealthNet Fee-for-Service Program.
- Dental services for pregnant women were limited to dentures and services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury. Services to prepare the mouth for dentures, such as examinations, X-rays, or extractions; ancillary denture services such as relining, rebasing, and repairs; and all other Medicaid State Plan dental services for pregnant women were covered through the MO HealthNet Fee-for-Service Program.
- Certain podiatry services were eliminated (procedure codes 11719, 11720, 11721, 11750, and 29540) for participants age 21 and over (except for pregnant women in ME codes 18, 43, 44, 45, and 61),
- Optometric services for participants age 21 and over (except for pregnant women in ME codes 18, 43, 44, 45, and 61) were limited to one eye examination every 2 years.
- Comprehensive day rehabilitation services for participants age 21 and over (except for pregnant women in ME codes 18, 43, 44, 45, and 61) were eliminated; and
- Durable medical equipment (DME) services were limited to prosthetic devices; respiratory equipment and oxygen, with the exception of CPAP, BiPAP, and nebulizers; wheelchairs; diabetic supplies and equipment; and ostomy supplies for participants age 21 and over (except for pregnant women in ME codes 18, 43, 44,

45, and 61). Regardless of age, participants with a home health plan of care receive DME services for the duration of their home health plan of care.

Effective July 1, 2006, the following changes to the MO HealthNet Managed Care Program occurred as a result of the passage of House Bill 1011 during Missouri's 93rd General Assembly 2006 legislative session:

- Optometric services for participants age 21 and over (except for pregnant women in ME codes 18, 43, 44, 45, and 61) were limited to eye examinations and one pair of eyeglasses following cataract surgery.
- Durable medical equipment (DME) services were limited to prosthetic devices; respiratory equipment and oxygen, with the exception of CPAP, BiPAP, and nebulizers; wheelchairs (including batteries and accessories); diabetic supplies and equipment; and ostomy supplies for participants age 21 and over (except for pregnant women in ME codes 18, 43, 44, 45, and 61). Regardless of age, participants with a home health plan of care receive DME services for the duration of their home health plan of care.

Effective September 1, 2007, the following changes to the MO HealthNet Managed Care Program occurred as a result of the passage of Senate Bill 577 during Missouri's 94th General Assembly 2007 legislative session:

- The MCOs were responsible for providing DME services for adults, including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, and diabetic supplies and equipment.

As a result of the passage of House Bill 11 during Missouri's 94th General Assembly 2007 legislative session, the Missouri General Assembly approved a statutory change for the MO HealthNet Division to develop a four-year plan to achieve parity with Medicare reimbursement rates for all providers. The statutory change affects MO HealthNet Managed Care reimbursement rates.

A physician fee increase was implemented effective July 1, 2007. Physician reimbursement rates that were less than 55% of the Medicare reimbursement rate were increased to 55%, physician reimbursement rates at 55% were unchanged, and physician reimbursement rates more than 55% were increased by 10%.

Effective July 1, 2007, the pharmacy dispensing fee paid to each qualifying pharmacy by the MCOs, for the first 1,000 prescriptions filled in any calendar quarter, was increased from $4.09 to $4.84.

As a result of the passage of House Bill 2011 during Missouri's 94th General Assembly, 2008 session, effective July 1, 2008, MO HealthNet Managed Care physician, dental, and optical rates were increased. MO HealthNet Managed Care physician reimbursement rates,

which are less than 62.5% of the Medicare reimbursement rate, increased to 62.5% of the Medicare reimbursement rate. MO HealthNet Managed Care dental reimbursement rates increased to 38.5% of the 50th percentile of UCR. MO HealthNet Managed Care Optical reimbursement rates for eye exams increased by $10.

As a result of the passage of House Bill 11 during Missouri's 95th General Assembly, 2009 session, MO HealthNet Managed Care dental reimbursement rates increased effective July 1, 2009. MO HealthNet Managed Care dental reimbursement rates are less than 38.75% of the 50th percentile of usual and customary rates (UCR), increased to 38.75% of the 50th percentile of UCR.

Effective October 1, 2009, dental and optical services for adults are no longer carved out of the MO HealthNet Managed Care comprehensive benefit package.

Effective October 1, 2009, pharmacy services were carved out of the MO HealthNet Managed Care comprehensive benefit package and covered by the MO HealthNet Fee-for-Service Program.

Effective October 29, 2010, MHD began reimbursement for smoking cessation for pregnant MHD eligible participants, including both behavioral and pharmacologic interventions covered through the MHD Fee-for-Service Program. On February 25, 2011, this benefit was expanded to all MHD eligible participants.

In accordance with the Patient Protection and Affordable Care Act (ACA) for calendar years 2013 and 2014:

- The MO HealthNet Fee-for-Service fee schedule reflected a payment increase for primary care services by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. The payment was not less than one hundred percent (100%) of the payment rate that would apply to such services under Medicare Part B. The health plan passed on the full benefit of the payment increase to eligible providers.
- The term "primary care services furnished by physicians" is defined as provided in 42 CFR Part 447, Subpart G. The payment increase for primary care services was not applicable for ME codes 73, 74, and 75.
- All physicians who attested before January 1, 2013, will be eligible for higher payments for dates of service on or after January 1, 2013. Physicians submitting forms on or after January 1, 2013, were eligible for higher payments for dates of service on or after the date the attestation was received by the health plan.
- At the end of CY 2013 and 2014, the state reviewed a statistically valid sample of physicians who received the increased payment to verify that the physicians met the requirements for the increased payment. If the state identifies a physician who was paid in error, the health plan will be notified and shall recoup the increased payment from the physician.

- The health plan must submit sufficient documentation for the selected sample in the format prescribed by the state to validate that the enhanced payments were made to eligible providers. The documentation should adequately document expenditures eligible for 100% FFP and support all audit and reconciliation processes. This documentation for the selected sample shall be provided to the state annually and upon request.

Effective January 1, 2016, the following changes to the MO HealthNet Managed Care Program occurred as a result of the passage of House Bill 11 during Missouri's 98th General Assembly 2015 legislative session:

- Ambulance, dental, complex rehabilitation (DME), health home, home health, physician, and rehabilitation procedure code rates will be increased up to and including 1% if the Medicare rate is not met. If the rate is already at the Medicare rate, then no increase will be implemented for that procedure code.
- Additional hospice daily payment rates were implemented:
  - routine home care daily payment for the first 60 days,
  - routine home care daily payment for days beyond 60 days,
  - Service Intensity Add-On (SIA) payment for a visit by a social worker or registered nurse when provided during routine home care in the last seven days of a patient's life.
- Adult dental coverage for trauma of the mouth, jaw, teeth, or other contiguous sites as a result of injury; treatment of a disease/medical condition without which the health of the individual would be adversely affected; preventive services; restorative services; periodontal treatment; oral surgery; extractions; radiographs; pain evaluation and relief; infection control; and general anesthesia.

Effective July 1, 2018, the following program changes were made to the Managed Care Program:

- Implemented the Show Me ECHO program, which integrates the efficiencies created by the use of video conferencing to connect providers with experts to achieve better health outcomes with a focus on high-risk obstetrics.
- Changed reimbursement requirements for non-participating hospitals and providers (with some exceptions) to 90% of the Fee-for-Service schedule.
- Approved the use of in lieu of services or settings, including medical daycare and the use of institutions for mental disease, for treatment of substance use for ages 21-64.
- Implemented same-day enrollment for children in foster care, adoption subsidy, and Division of Youth Services programs.
- Implemented a new Member Grievance and Appeal policy and process in accordance with federal regulations.

- Implemented the Alternative Therapies for Chronic Pain, which offers chiropractic services, acupuncture, physical therapy, and cognitive therapy as alternative treatments to the use of opioids.

Effective July 1, 2019, the following program changes were made to the Managed Care Program:

- Added a new performance improvement project, Follow-up After Hospitalization for Mental Illness, to develop program-wide strategies to increase the number and quality of follow-up visits for members discharged from inpatient treatment for mental illness.
- Implemented chiropractic services in addition to the services provided under the Alternative Therapies for Chronic Pain program.
- Carved in tobacco cessation counseling services.
- Implemented the Treat No Transport program that allows on-site treatment or referrals by emergency staff for members who do not need transport to the emergency room.
- Approved the use of Intensive Outpatient Program services, Partial Hospitalization Program services, and remote patient monitoring as in lieu of services or settings.

Effective January 1, 2024, the following changes were made to the Missouri Managed Care Program:

- Postpartum coverage for pregnant women was extended from 60 days after the birth of a child to a postpartum period of 12 months after the birth of a child.

Effective July 1, 2024, the following changes were made to the Missouri Managed Care Program:

- A new database, utilized by the Department of Health and Senior Services (DHSS), replaced MOHSAIC to document lead care management activities.
- Children who are determined eligible for Medicaid or CHIP at initial application or a regularly scheduled annual renewal remain eligible for Medicaid or CHIP for 12 months after the month of approval or renewal. This is called the Continuous Eligibility (CE) period. Children remain eligible during the CE period regardless of most changes in circumstances (CIC) that may affect eligibility.
    - 12 months of continuous eligibility (CE) for children under the age of 19 in Medicaid and the Children's Health Insurance Program (CHIP), starting with the month in which the child is approved for coverage, or the month in which the child's regularly scheduled annual renewal is completed.

Effective October 1, 2024, the following changes were made to the Missouri Managed Care Program:

- Transformation of Rural Community Health (ToRCH)
    - The health plan shall participate in MHD's Transformation of Rural Community Health (ToRCH) program.
    - Each health plan is invited to participate in the ToRCH Statewide Advisory Group to work collaboratively to improve the program in an advisory capacity.
- Certified Community Behavioral Health Organizations (CCBHOs)
    - The health plan reimbursement to CCBHOs shall be 100% of the state agency Fee-for-Service fee schedule, effective on the date of service.
- Doula Services shall be available for reimbursement.

Effective January 1, 2025, the following changes were made to the Missouri Managed Care Program:

- Rural Emergency Hospitals (REHs)
    - Hospitals that meet the federal definition found in 42 CFR 485.502. Health plans shall reimburse REHs within the network for outpatient services based on the state-plan-approved FFS outpatient fee schedule and will receive the same 40% additional payment as Critical Access Hospitals.
- Ground Emergency Medical Transportation (GEMT) Uncompensated Costs Program
    - MO HealthNet established a managed care payment to reimburse publicly owned ambulance services for their uncompensated Medicaid costs as of January 1, 2025.

Effective July 1, 2025, the following changes were made to the Missouri Managed Care Program:

- Some Missouri hospitals will be reimbursed with a Diagnosis-Related Groups (DRG) methodology instead of on a per diem basis.

Effective October 1, 2025, the following changes were made to the Missouri Managed Care Program:

- Prescribed Pediatric Extended Care
    - A Prescribed Pediatric Extended Care (hereinafter referred to as PPEC) licensed facility will provide a combination of private duty nursing (PDN), therapy (physical, occupational, and speech), and personal care to participants aged five and under (per PPEC licensure) who are assessed to need PDN services.

Stakeholder Partnership

The state believes that the keys to a successful managed care program include the provision of quality services, the satisfaction of enrollees, and the involvement and input of stakeholders to inform health care policy and service delivery. The following are examples of forums, workgroups, meetings and other efforts to engage our stakeholder partners:

- Periodic meetings with provider groups such as the Missouri Primary Care Association, the Missouri Dental Association, the Missouri Hospital Association, Quarterly Hospital Meetings, Dental Advisory Committee, Dental Task Force, Durable Medical Equipment Provider Meeting, the Drug Utilization Review Board, as well as individual providers.

- The MCOs each have a Member Advisory Committee or Group (MAC or MAG) to their members and community partners. These meetings have involved providing meals to members, inviting community partners, educating members on any Medicaid changes, and having Q&A sessions. The nature of these meetings was impacted by the COVID-19 pandemic, but the MCOs worked to offer virtual options during this time.

- The state has created a Beneficiary Advisory Council, the MO HealthNet Community Connection, to encourage meaningful communication between MHD and MO HealthNet participants in order to empower and educate them. The vision is to create a strong and active voice for MO HealthNet participants to improve their health care experience.

- MHD conducts frequent meetings and interactions with the Advocates for Family Health, an ombudsmen service, regarding ways to help individuals access care more easily and ways to coordinate care with other state agencies.

- The Quality Assurance and Improvement Advisory Group (QA&I), which is open to the public and includes all of the managed care organizations, state staff, other state agency staff, Advocates for Family Health, and other consumer advocates and interested parties.

- Periodic meetings with Cover Missouri, a group working to assist Missourians in obtaining health insurance.

- Collaboration and regular meetings with the Department of Health and Senior Services, the Department of Mental Health, and the Department of Elementary and Secondary Education, as well as with other divisions within the Department of Social Services.

- Special workgroups formed to enhance the quality of our programs and services, including the Encounter Data Workgroup, the Quality Data Validation Workgroup, and the Follow-up After Hospitalization for Mental Illness group.

- Publication of the RFP on the state website; publication of provider bulletins on the state's website regarding MO HealthNet Managed Care issues.

Program Populations

Children's Health Insurance Program

Missouri's Children's Health Insurance Program (CHIP), known as MO HealthNet For Kids, was a Medicaid expansion implemented on September 1, 1998 through a waiver under Section 1115 of the Social Security Act and a Title XXI Plan that covered children under the age of 19 in families with a gross income of 300 percent of the Federal poverty level (FPL). Coverage was provided through the MO HealthNet Managed Care delivery system in areas of the state covered by the Section 1915(b) waiver and through the MO HealthNet Fee-for-Service Program in the remainder of the state. Uninsured women losing their MO HealthNet eligibility sixty (60) days after the birth of their child are covered for women's health services for an additional year, regardless of their income level. This population received services through the MO HealthNet Fee-for-Service Program. Effective September 1, 2007, the CHIP Program transitioned to a combination CHIP State Plan and the Women's Health Services Program transitioned to the Missouri Women's Health Services Program Section 1115(a) Demonstration Waiver.

Combination State Children's Health Insurance Program

Effective September 1, 2007, the Centers for Medicare and Medicaid Services (CMS) approved Missouri's request for a combination Children's Health Insurance Program (CHIP). The CHIP combination program is comprised of a MO HealthNet Expansion and a Separate Child Health Program.

MO HealthNet Expansion

Missouri provided presumptive eligibility for children in families with income of 150% of FPL or below until a decision was made on regular MO HealthNet For Kids Program eligibility. Under the MO HealthNet expansion, uninsured children ages one through five with family income more than 148% of the Federal Poverty Level (FPL) but less than 151% of the FPL and uninsured children ages 6 through 18 with family income more than 148% of the FPL but less than 151% of the FPL are covered.

Children eligible for the MO HealthNet expansion program receive the MO HealthNet package of essential medically necessary health services, including Non-Emergency Medical Transportation (NEMT). Prescription drugs are subject to the national drug rebate

program requirements. Title XXI eligibles are enrolled in MO HealthNet Managed Care. No new eligible individuals are excluded because of pre-existing illness or condition.

MO HealthNet For Kids Program (Separate Child Health Insurance Program)

Uninsured children under the age of one with family income more than 196% of the Federal poverty level (FPL), but less than 300% of the FPL, and uninsured children age one through age 18 with family income between 151% and 300% of the FPL are covered under a Separate Child Health Program entitled the MO HealthNet For Kids Program. The MO HealthNet For Kids Program occurs under a Title XXI CHIP State Plan. No new eligible is excluded because of a pre-existing illness or condition. Children in families with income above 150% of FPL are not eligible if they have access to affordable insurance, and the family must pay a monthly premium.

Children eligible for the MO HealthNet For Kids Program receive a benefit package of essential medically necessary health services, excluding NEMT. Prescription drugs are subject to the national drug rebate program requirements. Title XXI eligible individuals are enrolled in MO HealthNet Managed Care.

MO HealthNet Show-Me Healthy Babies Program (Separate Child Health Insurance Program)

Targeted low-income pregnant women and unborn children receive a benefit package of essential, medically necessary health services identical to the MO HealthNet for Pregnant Women benefit package. These individuals enroll in a MO HealthNet Managed Care Health plan.

This program is for targeted low-income pregnant women and unborn children from conception to the date of birth, with household incomes up to 300% of the FPL. Pregnant women shall not be otherwise eligible for coverage under the Medicaid Program, as it is administered by the state, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. For targeted low-income pregnant women, postpartum coverage will begin on the last day of the pregnancy and extends through the end of the month in which the 12-month postpartum period ends. The unborn child's coverage period will be from the date of application to birth.

Nurse Case Management (NCM)

Missouri operated a Nurse Case Management Program from March 14, 2002, to June 30, 2018. The Nurse Case Management Program ended on June 30, 2018, as did the contract with Cornerstones of Care, the organization with which the state was collaborating to carry out the program. Missouri now contracts statewide with MCOs, which are required to offer care management to children in the care and custody of the state. To ensure seamless care management of these children, Missouri will focus on the transition of care management

of these children to the MCOs. One tool developed for this transition is a file that is provided to the MCOs on a nightly basis with the most recent contact information for authorized representatives of these children. Missouri required these children to be enrolled with an MCO the same day they were determined eligible for MO HealthNet Managed Care. They will continue to be able to change their MCO at any time.

Transformation of Rural Community Health (ToRCH)

Effective April 1, 2024, Missouri launched a new initiative called Transformation of Rural Community Health (ToRCH) to address rural population health. ToRCH is a hub-based model that is designed to allow rural communities the flexibility to address health-related social needs (HRSN) within their Medicaid populations in a manner that focuses on improving health outcomes. Initial enrollment across six ToRCH counties is estimated to be 41,390 as of April 1, 2024.

ToRCH entities are rural community health hubs – specifically rural hospitals, in the pilot cohort – that will provide community-level care management services, i.e., strategic coordination of community-based services that primary care partners are then able to utilize in a systematic way to more fully support positive health outcomes on the individual patient level. Under authority of §1905(t) of the Social Security Act, which defines primary care case management as the "locating, coordinating, and monitoring of health care services," the ToRCH entities engage Community Based Organizations (CBO) partners to participate in a Community Information Exchange (CIE) platform, i.e. to *locate* HRSN services that individual case managers and other screening providers can use to better *coordinate* across the clinic and multiple CBOs, and to *monitor* enrolled members in need of HRSN services.

This program moves the health care delivery system closer to integration with community-based services that support overall health goals. Data-driven, population-based care management strategies will inform coordination between medical providers and CBO partners. Utilization of the (b)(3) authority allows MHD to pay for HRSN services that are correlated with better health outcomes and reductions in health care spending. The ToRCH care coordinators will provide a variety of community care management activities, including educating providers and CBOs on the value of using the CIE, monitoring closed-loop referral metrics and performance across CBOs, analyzing community health care quality and claims data and sharing analytics with ToRCH partners to inform the evolution of population health strategies in the community.

A. Statutory Authority

1. **Waiver Authority.** The state's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the state is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program is authorized by this waiver, please list applicable programs below each relevant authority):

a. **X** **1915(b)(1)** – The State requires enrollees to obtain medical care through specialty physician services arrangements. This includes mandatory capitated programs.

MCO and ToRCH

b. **X** **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing MCOs in order to provide enrollees with more information about the range of health care options open to them.

MCO General Plan Only

c. **X** **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

Waiver for ToRCH Only (but includes MCO enrollees in ToRCH program)

d. **X** **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

X MCO
___ PIHP
___ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a Fee-for-Service Medicaid contracting provider.)
___ FFS Selective Contracting program (please describe)
___ Other (please identify programs)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. _X_ **Section 1902(a)(1)** - Statewideness -This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

RESPONSE: Not waived for MCO; waive for ToRCH as services are only available in selected rural counties.

b. _X_ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

RESPONSE: MCO, including ToRCH

c. _X_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO.

RESPONSE: MCO, ToRCH

d.___ **Section 1902(a)(4) -** To permit the State to mandate beneficiaries into a single PIHP or PAHP and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

e. _X_ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive and include an explanation of the request.

RESPONSE: A waiver of 438.52 is requested through a Section 1115 Demonstration to mandatorily enroll all members eligible for the Specialty Plan into a single MCO.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a. _X_ **MCO:** Risk-comprehensive contracts are fully capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory state plan service in section 1905(a), or any three or

more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

RESPONSE: MCO

b.___ **PIHP:** Prepaid Inpatient Health Plan means an entity that:

(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

___ The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

c.___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

d._**X**_ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a Fee-for-Service basis. Note: A capitated PCCM is a PAHP.

RESPONSE: ToRCH will supply a community-level strategy, i.e. a community-PCCM entity operating a HRSN/PCCM model for Medicaid-enrolled individuals who reside in the rural community where the ToRCH entity is located. ToRCH beneficiaries living in selected rural counties will be served by the single ToRCH entity providing community-PCCM services for that county; however, the beneficiary will have choice of providers and case managers to work with on an individual basis at identifying and resolving HRSNs.

e. ___ **Fee-for-Service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f. _ _ **Other:** (Please provide a brief narrative description of the model.)

RESPONSE:

2. **Procurement**. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g., procurement for MCO; procurement for PIHP, etc.):

_X_ **Competitive** procurement process (e.g., Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

RESPONSE: MCO

RESPONSE: ToRCH - Notice of the ToRCH program opportunity was circulated widely, including a presentation to the Missouri Hospital Association's Rural Hospital Council at their annual meeting. MO HealthNet conducted several webinars for stakeholders that provided a detailed summary of the ToRCH pilot project as it was under development. Those expressing interest in participating in the pilot received targeted technical assistance and data sharing, and more details on application planning. They submitted non-binding letters of intent to apply by January 31, 2023.

The formal application process opened on February 23, 2023, with applications due to MO HealthNet on May 31, 2023. The ToRCH application was open to all Missouri hospitals with a short-term acute care hospital meeting the definition of "rural county/counties", defined as hospitals in counties deemed eligible for rural-targeted funding in the Federal Office of Rural Health Policy.

___ **Open** cooperative procurement process (in which any qualifying contractor may participate)
___ **Sole source** procurement
___ **Other** (please describe)

C. Choice of MCOs

1. **Assurances.**

_**X**_ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which requires that a State that mandates Medicaid beneficiaries to enroll in an MCO must give those beneficiaries a choice of at least two entities.

___ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

RESPONSE: A waiver of 438.52 is requested through a Section 1115 Demonstration to mandatorily enroll all members eligible for the Specialty plan into a single MCO.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

_**X**_ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_**X**_ Other: (please describe)

RESPONSE: A waiver of 438.52 is requested through a Section 1115 Demonstration to mandatorily enroll all members eligible for the Specialty plan into a single MCO.

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

___ Beneficiaries will be limited to a single provider in their service area (please define service area).
___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

   _X_ **Statewide** -- all counties, zip codes, or regions of the State for MCO program

   _X__ **Less than Statewide** – for ToRCH program

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Eastern Region – Counties: Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, St. Louis County, Ste. Genevieve, Warren, Washington, and St. Louis City	MCO	1) Home State Health Plan, Inc. 2) UnitedHealthcare of the Midwest, Inc. 3) Missouri Care, Inc. DBA Healthy Blue
Western Region – Counties: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, and Vernon	MCO	1) Home State Health Plan, Inc. 2) UnitedHealthcare of the Midwest, Inc. 3) Missouri Care, Inc. DBA Healthy Blue

Central Region – Counties: Adair, Andrew, Atchison, Audrain, Benton, Bollinger, Boone, Buchanan, Butler, Caldwell, Callaway, Camden, Cape Girardeau, Carroll, Carter, Chariton, Clark, Clinton, Cole, Cooper, Crawford, Daviess, DeKalb, Dent, Dunklin, Gasconade, Gentry, Grundy, Harrison, Holt, Howard, Iron, Knox, Laclede, Lewis, Linn, Livingston, Macon, Maries, Marion, Mercer, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Nodaway, Osage, Pemiscot, Pettis, Phelps, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Saline, Schuyler, Scotland, Scott, Shelby, Stoddard, Sullivan, Wayne, and Worth	MCO	1) Home State Health Plan, Inc. 2) UnitedHealthcare of the Midwest, Inc. 3) Missouri Care, Inc. DBA Healthy Blue
Southwestern Region – Counties: Barry, Barton, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Lawrence, McDonald, Newton, Oregon, Ozark, Shannon, Stone, Taney, Texas, Webster, and Wright	MCO	1) Home State Health Plan, Inc. 2) UnitedHealthcare of the Midwest, Inc. 3) Missouri Care, Inc. DBA Healthy Blue
Counties: Dent, Henry, Pettis, Phelps, Polk, Ray	HRSN/ PCCM (ToRCH)	ToRCH Community Hub Model

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program:

RESPONSE:

ToRCH includes all of the populations below in its scope and budgeting; however, no individual is mandated to receive the individual-level HRSN screenings or services that are offered as part of ToRCH. However, all Medicaid beneficiaries will stay enrolled with the ToRCH program to continue with data monitoring for unmet needs and additional outreach as identified. Thus, all populations below are "mandatorily enrolled" in ToRCH for waiver purposes. The responses below pertain to the MCO program only.

_X_ **Section 1931 Children and Related Populations** are children, including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

_X_ Mandatory enrollment - MCO
___ Voluntary enrollment

_X_ **Section 1931 Adults and Related Populations** are adults, including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

_X_ Mandatory enrollment - MCO
___ Voluntary enrollment

___ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

___ Mandatory enrollment
___ Voluntary enrollment

___ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

___ Mandatory enrollment
___ Voluntary enrollment

___ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

___ Mandatory enrollment
___ Voluntary enrollment

_X_ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

_X_ Mandatory enrollment - MCO
___ Voluntary enrollment

RESPONSE:

Effective July 1, 2007, individuals who were independent foster care adolescents, age 18 to 21, were eligible for coverage without regard to income or assets. These individuals had an opportunity to enroll in an MCO in areas of the state served by the MO HealthNet Managed Care Program. In areas of the state where MCOs were not operational, these individuals received benefits from the MO HealthNet Fee-for-Service Program. These individuals received all services specified in the comprehensive benefit package for children under 21 years of age. This change extended coverage to approximately 970 individuals. The state anticipated that approximately 175 individuals were eligible for coverage under the MO HealthNet Managed Care Program.

Effective August 28, 2013, individuals who were independent foster care adolescents, ages 21 through 25, were eligible for coverage without regard to income or assets. These individuals received the services specified in the comprehensive benefit package for children in state care and custody, less than 21 years of age, to include Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings. All services for these individuals were funded through General Revenue (state only) funds for the period August 28, 2013, through December 31, 2013. These individuals had the opportunity to enroll in a MO HealthNet Managed Care health plan in areas of the state served by the MO HealthNet Managed Care Program. In areas of the state where MO HealthNet Managed Care MCOs were not operational, these individuals received benefits from the MO HealthNet Fee-for-Service Program. This change extended coverage to approximately 2,655 individuals.

Effective January 1, 2014, individuals who were independent foster care adolescents, ages 21 through 25, received a comprehensive benefit package for

children in state care and custody, but EPSDT screening and EPSDT services not covered by the Medicaid State Plan will be excluded.

Effective May 1, 2017, the State of Missouri expanded Managed Care statewide to encompass all counties of Missouri, including St. Louis City.

Effective July 1, 2022, individuals who are in the care and custody of the state and receiving adoption subsidy assistance, independent foster care youth, former foster care youth, and former foster care youth from out of state will receive a comprehensive benefit package from the MO HealthNet Managed Care Program's Specialty Plan. The state will automatically enroll these individuals into the specialty health plan, and they will remain enrolled in the specialty health plan until any of the following occur:

- The enrollee qualifies for Supplemental Security Income, and the enrollee or the enrollee's guardian chooses to disenroll from managed care;
- The enrollee meets the qualifications described in Section 501 (a)(1)(D) of the Act and chooses to disenroll from managed care;
- The enrollee meets the qualifications described in Section 1902 (e)(3) of the Act and chooses to disenroll from managed care; or
- The enrollee is no longer in the care and custody of Missouri nor receiving adoption subsidy assistance and is automatically disenrolled from the specialty health plan.

_X_ **TITLE XXI CHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the Children's Health Insurance Program (CHIP) through the Medicaid program.

_X_ Mandatory enrollment - MCO
___ Voluntary enrollment

RESPONSE:

Effective September 1, 2007, Missouri provides presumptive eligibility for children in families with income of 150% of FPL or below until an eligibility decision is made. Uninsured children age one through age five with family income more than 133% of the Federal Poverty Level (FPL) but less than 151% of the FPL, and uninsured children ages 6 through 18 with family income more than 100% of the FPL but less than 151% of the FPL are covered under the MO HealthNet expansion.

Children eligible for the MO HealthNet expansion program receive the MO HealthNet package of essential medically necessary health services, including Non-Emergency Medical Transportation (NEMT). Prescription drugs are subject to the national drug rebate program requirements. Title XXI eligibles are enrolled in MO HealthNet Managed Care. No new eligible individuals will be excluded because of pre-existing illness or condition.

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

   RESPONSE:

   The ToRCH program only excludes those with retroactive eligibility. All other listed populations are included in ToRCH. Therefore the responses below pertain to the MCO program only.

   _X_ **Medicare Dual Eligible** – Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

   ___ **Poverty Level Pregnant Women** – Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

   ___ **Other Insurance** – Medicaid beneficiaries who have other health insurance.

   _X_ **Reside in Nursing Facility or ICF/MR** – Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR). – MCO only

   ___ **Enrolled in Another Managed Care Program** – Medicaid beneficiaries who are enrolled in another Medicaid managed care program.

   ___ **Eligibility Less Than 3 Months** – Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

   _X_ **Participate in HCBS Waiver** – Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver). – MCO only

RESPONSE:

Exception: Developmental Disability (DD) Waiver participants in all MO HealthNet Managed Care regions are included in the MO HealthNet Managed Care Program. However, their DD Waiver services are not included in the MO HealthNet Managed Care Program.

Autism Waiver participants in all MO HealthNet Managed Care regions are included in the MO HealthNet Managed Care Program. However, their Autism Waiver services are not included in the MO HealthNet Managed Care Program.

Adult Day Care Waiver participants in all MO HealthNet Managed Care regions are included in the MO HealthNet Managed Care Program. However, their Adult Day Care Waiver services are not included in the MO HealthNet Managed Care Program.

To ensure that there is no duplication of services ToRCH administrators will receive training to ensure they are knowledgeable on the services available for those populations, and that they confirm through checking the participant's ME code and/or contacting their local operating agencies that the participant is not eligible through those waivers.

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

RESPONSE:

Individuals with special health care needs are included. Persons with SSI are allowed to opt out. Missouri is a 209(b) state. There are no specific eligibility categories for the special health care needs population. These individuals are included in the general 1915(b) population.

Medicaid eligibles in the above specified eligibility groups who are eligible for SSI under Title XVI of the Social Security Act, described in Sections 501(a)(1)(D) and 1902(e)(3), receiving foster care or adoption subsidy assistance under part E of Title IV of the Social Security Act, in foster care or otherwise in out-of-home placement, or meet the SSI disability definition as determined by the state may choose not to enroll or voluntarily disenroll from the MO HealthNet Managed Care program at any time.

___ **CHIP Title XXI Children** – Medicaid beneficiaries who receive services through the CHIP program.

_X_ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

_X_ **Other** (Please define):

RESPONSE:

MCO

- Individuals eligible for Aid to the Blind and Blind Pension.
- Permanently and Totally Disabled and Aged individuals.
- Individuals eligible under Juvenile Court. This population will obtain their services through the MO HealthNet Fee-for-Service Program.
- Individuals residing in a State Mental Institution or an Intermediate Care Facility for the Intellectually Disabled
- Any individual who is eligible and receiving either or both Medicare Part A and Part B or Part C benefits
- Pregnant women who are eligible for the Presumptive Eligibility Program.
- Uninsured women losing their MO HealthNet eligibility could be eligible for women's health services if they are not eligible for other MO HealthNet programs providing higher levels of coverage. This population will obtain their services through the MO HealthNet Fee-for-Service Program.
- Individuals eligible under Presumptive Eligibility for Children
- Breast and Cervical Cancer Treatment (BCCT) participants.
- Individuals eligible under Voluntary Placement Agreement for Children.
- Children placed in foster homes or residential care by the Department of Mental Health.
- AIDS Waiver participants.
- Individuals eligible under MO Children with Developmental Disabilities Waiver.
- Individuals eligible under Qualified Medicare Beneficiary – QMB.
- Children placed in residential care by their parents, if eligible for MO HealthNet on the date of placement.
- Individuals under the Temporary Assignment Category.
- Individuals eligible under the Missouri Rx program (MORx).

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

_X_ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

___ The state seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

_X_ The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts are effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. The initial contracts will be submitted to CMS upon award.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

_X_ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

_X_ The MCO will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
_ __ Other (please explain):

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

_X_ The program is **mandatory**, and the enrollee is guaranteed a choice of at least one MCO which has at least one FQHC as a participating provider. If the enrollee elects not to select an MCO that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO with a participating FQHC:

RESPONSE:

MCO

The MCO is required by contract to include Federally Qualified Health Centers (FQHCs) in its provider network. All of the MCOs are required to include at least one FQHC in their provider network.

___ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

RESPONSE:

5. **EPSDT Requirements.**

_X_ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

_X_ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

Proposed (b)(3) service	Unit of service	Unit of payment	Covered population
Expanded Supplemental health-related transportation for a Medicaid participant to: • attend a SNAP or WIC appointment, including job/skills services under SNAP • seek out a community resource from a ToRCH partner to whom the participant is referred during screening	round-trip ride	Flat base fee per round-trip ride plus a marginal rate per mile	Medicaid residents of each ToRCH county who screen positive for transportation insecurity (Z59.82) This service is in addition to medical transportation required under 42 CFR 431.53 and transportation services under the state plan, defined at 42 CFR 440.170(a) (if applicable), and does not replace them.
Supplemental health-related transportation for a Medicaid participant to attend: • a group counseling session not otherwise covered under the Medicaid benefit for weight loss or addiction treatment (alcohol, tobacco, SUD, etc.)	round-trip ride (could be pre-authorized as a series corresponding to a class being offered)	Flat base fee per round-trip ride plus a marginal rate per mile	Medicaid residents of each ToRCH county who screen positive for transportation insecurity (Z59.82) This service is in addition to medical transportation required under 42 CFR 431.53 and transportation services under the state plan, defined at 42 CFR 440.170(a) (if applicable), and does not replace them.
Nutritional counseling and education to: • teach Medicaid participants how to leverage SNAP and	60-minute session (could be pre-authorized as a series if a class	Fee per 60-minute session	Medicaid residents of each ToRCH county who screen positive for food insecurity (Z59.4, Z59.41, or

WIC benefits at the grocery store to purchase healthier foods • develop cooking skills to complement the above, including providing recipes that are culturally acceptable and feasible to prepare at home	format is offered); limit of 6 total		59.48) and who are pregnant, postpartum, and/or have a diagnosis of obesity or overweight, diabetes or pre-diabetes, hypertension, kidney disease, or are at risk of developing these or other diet-related chronic conditions
Home-delivered meals to: • provide one highly nutritious meal per day that is specifically targeted to address a chronic health condition • this service will not exceed 2 meals a day or constitute a full nutritional regime • at the participant's request, meals could also be picked up if more convenient for them for any reason (e.g., during the same doctor visit where need is identified)	7 days of meals (could authorize up to 4 weeks at a time; renewable upon physician recommendation); could be delivered once/week as a combination of fresh and frozen	Fee per 7 days of meals delivered (or picked up)	Medicaid residents of each ToRCH county who screen positive for food insecurity (Z59.4, Z59.41, or 59.48) and transportation insecurity (Z59.82) who are pregnant, postpartum, and/or have a diagnosis of obesity or overweight, diabetes or pre-diabetes, hypertension, or kidney disease, or are at risk of developing these or other diet-related chronic conditions
• **Environmental modifications** are physical modifications to the home of the Medicaid participant that are necessary to ensure the health, welfare, and safety of the participant or enable the participant to function with	• Variable depending on the type of service, but typically one service per participant • Includes installation of ramps and grab-bars,	Variable, but with an annual limit per participant and a PA process administered by the ToRCH entity	Medicaid residents of each ToRCH county who screen positive for housing problems (Z59, Z59.1)

greater independence in the home.	widening of doorways, modification of bathroom facilities, or installation of specialized electric or plumbing systems needed to accommodate medical equipment		
Environmental goods and services are goods and services provided to the home of the Medicaid participant to: • improve the air quality and breathability • mitigate unsafe conditions due to pests, e.g., bedbugs, roaches	• mold removal • dehumidifier purchase • A/C window or wall unit installation • pest removal or abatement	Variable, but with an annual limit per participant and a PA process administered by the ToRCH entity	Medicaid residents of each ToRCH county who screen positive for housing problems (Z59, Z59.1) and who have a diagnosis related to breathing difficulty, such as asthma, COPD, emphysema, etc., or whose home environment poses an immediate health or safety risk

7. **Self-referrals.**

_X_ The State requires MCOs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO contract:

RESPONSE:

MCO

Enrollees may access in-network behavioral health and substance use disorder services without a referral from their primary care provider (PCP). These services include Medication Assisted Treatment involving behavioral health counseling as well as medication for substance use disorders. Enrollees may access in-network behavioral health and substance use disorder providers directly without a referral

or prior authorization. Enrollees may access in-network OB/GYN providers in accordance with state statutory provisions.

MCOs are required to develop policies and procedures that address whether there is a need for referral by the PCP or self-referral for second opinions. MO HealthNet Managed Care enrollees may self-refer to the following core services provided by local public health agencies:

- All sexually transmitted disease (STD) services, including screening, diagnosis, and treatment,
- Human immunodeficiency virus (HIV) services relating to screening and diagnostic studies,
- Tuberculosis services, including screening, diagnosis, and treatment,
- Childhood immunizations, and
- Childhood lead poisoning prevention services, including screening, diagnosis, treatment, and follow-up as indicated.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. **Assurances for MCO program.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts are effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods beginning July 1, 2023. Initial contracts will be submitted to CMS upon award.

If the 1915(b) Waiver Program does not include a NCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

RESPONSE:

Sections a, b, and c are not applicable to ToRCH as an HRSN/PCCM model that focuses on community-level strategy. Please see Section d.

a. _ n/a __ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

b. _ n/a __ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. _n/a__ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. **__X__ Other Access Standards** (please describe)

RESPONSE:

ToRCH includes infrastructure that ensures that community partners are engaged to meet HRSN issues with referrals and use of (b)(3) services where appropriate throughout the geographic community (i.e., the county) being served by the ToRCH entity. Referral patterns and community partners will be continually monitored to ensure that referrals are closed, and any low closure rates by geographic sub-region (i.e., zip code, Census block, etc.) will be addressed by the ToRCH entity in a timely manner. The ToRCH Leadership Board in each community will develop a

corrective action plan and ensure that access to CBO community partners providing HRSN services is high across the county. The overall standards of at least an 80% referral acceptance rate and a 70% case resolution rate will be assessed within CBO categories and within geographic sub-regions of the county. The ToRCH entity and MHD will monitor use of transportation-focused (b)(3) services to ensure these are deployed appropriately to improve any access deficiencies.

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

B. Capacity Standards

1. **Assurances for the MCO program.**

_X_ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts were effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Contracts will be submitted to CMS upon award.

If the 1915(b) Waiver Program does not include a NCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

RESPONSE:

Items (a) through (f) are not applicable to ToRCH as an HRSN/PCCM model that focuses on community-level strategy. Please see Item (g).

a._ n/a_ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b._ n/a_ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.

c._ n/a_ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d._ n/a_ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

e._ n/a_ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f._ n/a_ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	***PCCM-to-Enrollee Ratio***
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. **__X__Other capacity standards** (please describe):

RESPONSE:

ToRCH sites were selected on the basis of leadership capacity and demonstrated ability to engage primary care and community-based partners. MO HealthNet will monitor rates of HRSN screenings conducted by the ToRCH primary care and behavioral health partners and will monitor participation by the community-based

organizations in accepting referrals to ensure that capacities to perform these roles are not exceeded. The local ToRCH Leadership Boards will identify solutions to increase capacity as needed.

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

1. **Assurances for the MCO program.**

_X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts were effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Contracts will be submitted to CMS upon award.

2. **Details on MCO enrollees with special health care needs**.

The following items are required.

a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. **X** **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, as those persons are defined by the State. Please describe.

RESPONSE: Missouri is a 209 (b) state and does not track individuals with Social Security Income (SSI) as a separate eligibility group. A process was developed and maintained to identify enrollees with special health care needs. This information is communicated to the MCOs monthly. The information contains identifying information regarding enrollees in the following subpopulations: individuals eligible for SSI under Title XVI; individuals in foster care or other out-of-home placement, individuals receiving foster care or adoption subsidy; and individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state in terms of either program participant or special health care needs. A separate communication process is utilized to inform MCOs of their members who receive health home services.

The progress made to date has focused on the development and implementation of processes for the identification and assessment of individuals with special health care needs.

To ensure that MCOs meet the needs of persons with special health care challenges, the state's policies emphasize uninterrupted care. Special attention has been given to the transition of care from Fee-for-Service to MO HealthNet Managed Care. For example, prior to discontinuing any personal care services, the MCO must work with the state to evaluate the continuing needs of the enrollee.

A communication process has been established with MCO case managers. State staff are in communication with MCO case managers on a frequent basis regarding care issues.

c. **X** **Assessment**. Each MCO will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

RESPONSE:

MCO

The MCOs of the General and Specialty Plan must offer care management to all enrollees.

Member Care Management (CM) Program Requirements:

1) The MCO's CM staff shall be composed of individuals with diverse specialties and experience with the kinds of conditions that precipitated the need for CM;
2) The MCO must be able to demonstrate their CM staffing requirements and provide a formula used to determine CM staff to patient ratios;
3) The MCO shall integrate physical health and behavioral health CM staff;
4) The MCO's CM approach shall include both consistent interpersonal engagement as well as integrated CM systems with evidence of documentation in the enrollee's Care Plan;
5) The MCO shall utilize support staff integration through activities including, at a minimum, case conferences, development of multidisciplinary, and shared Care Plans;
6) The MCO shall provide a detailed CM Plan at the time of the readiness review and shall obtain the state's approval prior to implementation. Annually thereafter, the MCO shall provide an updated plan by July 1. The update shall include an evaluation of the MCO's CM effectiveness and provide adjustments for the upcoming year;
7) The MCO shall participate in an annual CM evaluation that is based on the patient Journey model. The state will provide additional information regarding this model following the contract award.

General Health Plan Policy Requirements – The MCO shall have policies and procedures in place for CM that include, at a minimum, the following:

1) If the MCO wants to use Local Public Health Agencies (LPHAs) to provide services, the health plan shall enter into written contracts as well as develop and provide written policies describing the scope of care with the LPHAs. (The MCO shall not be required to contract with outside entities for prenatal care management activities);
2) A description of the system for identifying, screening, and selecting members for each individual CM service, including risk stratification;

3) A description of the mechanism for which enrollees are informed of CM services and information communicated, which includes, at a minimum, the following:

   - The nature of the CM relationship and the impact it may have on positive enrollee outcomes;
   - The goal of CM, which includes engagement to empower enrollees and encourage their participation in their own plan of care through goral setting and integrated pathway management to improve outcomes and the overarching patient experience;
   - Circumstances under which information will be disclosed to third parties;
   - The availability of a complaint process; and
   - The rationale for implementing CM services.

4) A description of provider and enrollee profiling activities;

5) A description of procedures for conducting provider education on CM services to ensure provider support and contribution to enrollee education;

6) A description of a standardized Care Planning process, which includes documentation consisting of, at a minimum, the following:

   - Addition or removal of Care Plan goals;
   - Achievement of or failure to reach collaborative goals;
   - Interventions and closures to CM;
   - Evidence of use of clinical practice guidelines (including CyberAccess) to monitor progress and other pertinent changes to the care plan;
   - Evidence of routine Care Plan updates at least quarterly and following every enrollee/family touch, provider interaction, service utilization, and any other pertinent event;
   - Evidence of enrollee/family engagement and collaborative efforts to empower members and their families to promote ownership of health outcomes; and
   - Mechanism to track CM activities, whether they be DM related or any other CM activity.

7) A description of the type of data and information (e.g., health plans claims data, readmissions, prescription drug utilization data) and how the health plan will use the data to inform CM (i.e., individually and systemically);

8) A description of the mechanism to ensure that the PCP, enrollee parent/guardian, case worker, specialists caring for the enrollee and any other discipline contributing to the integrated treatment approach have access to the plan of care;

9) A description of the mechanism used to evaluate CM services that have been contracted by third-party entity to ensure at least minimum standards for CM delivery are being met;

10) A description of mechanism in place to ensure coordination and communication between physical and behavioral health providers is available to support an integrated service delivery approach;

11) A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned;

12) A description of the methodology used for assigning and monitoring CM caseloads that ensures adequate staffing to meet CM requirements;

13) A description of care manager training and stated qualifications needed to effectively manage care across the integrated healthcare spectrum;

14) A description of the evaluation process to determine efficacy of CM services;

15) Criteria for CM closure and mechanism for PCP notification of closure;

16) A description of documented adherence to any applicable state quality assurance, certification review standards, and practice guidelines, as described herein; and

17) A description of the mechanism used to be able to report each and every condition for which an enrollee is being managed, including stop and start dates for each condition.

The MCOs of the General and Specialty Plan are required to offer care management and disease management to enrollees. The MCOs must offer care management to all pregnant enrollees. The MCO must offer case management within fifteen (15) business days of date effective with the MCOs for newly eligible enrollees or within fifteen (15) business days of notice of pregnancy for current eligible enrollees. The initial care management and admission encounter shall be conducted face-to-face or by phone and include an assessment of the enrollee's needs.

The MCOs must perform an assessment for care management within thirty (30) calendar days of enrollment for new enrollees who present with a diagnosis listed below. New enrollees include those who have reenrolled with the plan after a lapse of ineligibility of more than sixty (60) days. The MCOs must perform an

assessment for care management within thirty (30) calendar days of diagnosis for existing enrollees who receive a new diagnosis listed below:

- Diabetes;
- Obesity;
- Hypertension;
- Asthma;
- Chronic Obstructive Pulmonary Disease (COPD);
- Attention Deficit/Hyperactivity Disorder (ADHD);
- Congestive Heart Failure;
- Cancer;
- Chronic Pain with opioid dependence;
- Hepatitis C in active treatment;
- HIV/AIDS;
- Organ failure requiring supportive treatment and potentially requiring transplant (e.g., ESRD and dialysis requirement or pancreatic/hepatic failure);
- Sickle Cell Anemia;
- Individuals with special health care needs, including those individuals who, without services such as private duty nursing, home health, durable medical equipment/supplies, or CM, may require hospitalization or institutionalization. The following groups of individuals are at high risk of having special health care needs:

    - Individuals with Autism Spectrum Disorder;
    - Individuals eligible for Supplemental Security Income (SSI);
    - Individuals with serious mental illness, including, at a minimum: schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, major depression, reactive attachment disorder of childhood, disruptive mood dysregulation disorder, oppositional defiant disorder, separation anxiety disorder of childhood and moderate to severe substance use disorder; and

- Any other condition for which the health plan determines the enrollee would benefit from care management services.

Disease Management (DM) shall be defined as the process of intensively managing a particular disease or syndrome. DM shall encompass all settings of care and shall place a heavy emphasis on prevention and maintenance. Similar principles shall apply to DM as in CM, but DM shall be more focused on a defined set of goals relative to a disease process. Members with one or more of the following disease conditions shall be eligible to receive DM services:

- Asthma/COPD;

- Depression;
- Obesity;
- Multiple Comorbid Conditions; and
- Any other disease condition for which the health plan determines the member would benefit from DM services.

Necessary components specific to DM include, at a minimum, the following:

- The health plan shall offer DM to members as early in the development of the disease state as possible;
- The health plan shall operate its DM programs using an "opt out" methodology, meaning that DM services shall be provided to eligible members unless they specifically ask to be excluded;
- The health plan shall emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization or improvements in condition-specific health status indicators;
- The health plan shall utilize evidence-based clinical practice guidelines that have been formally adopted by the health plan's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee;
- The health plan shall have methods for informing and educating providers regarding the clinical practice guidelines. The health plan shall distribute the guidelines to providers who are likely to treat members with DM conditions. This includes, at a minimum, PCPs and specialists involved in treating that particular condition. The health plan shall also provide each PCP with a list of their members enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The health plan shall provide specific information to the provider concerning how the program(s) works. The DM provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions; and
- The passive participation rates (as defined by the National Committee for Quality Assurance (NCQA) and the number of individuals participating in each level of each of the DM programs.

The MCOs must offer care management within the following timeframes to all children when knowledge of elevated blood lead levels is present:

- 3.5 to 9 μg/dL within five (5) business days;
- 10 to 19 μg/dL within one to three (1-3) business days;
- 20 to 44 μg/dL within one to two (1-2) business days;
- 45 to 69 μg/dL within twenty four (24) hours; and
- 70 μg/dL or greater – immediately.

The MCOs must provide an assessment for care management for all enrollees experiencing one (1) of the following:

- After re-admission; or
- After a stay of more than two (2) weeks.

The MCOs must conduct such assessments within thirty (30) calendar days of:

- The date upon which an enrollee receives the projected discharge date from hospitalization or rehabilitation facilities; or
- The last day of the month following the end of a quarter in which an enrollee has had three or more emergency department visits as identified through analysis of utilization data.

The MCOs must assess enrollees for care management within five (5) days of admission to a psychiatric hospital or residential substance abuse treatment program.

In addition to the requirements above the MCO of the Specialty Plan must provide the enrollees of the Specialty Plan with the following:

Specialty Plan Care Management Requirements:

- The MCO shall serve as the hub for CM services for Specialty Plan enrollees. The MCO shall support and augment CM activities performed by other entities including, at a minimum, those subcontracted by the MCO (e.g., medical homes, primary care and CMHC health home providers, Local Community Care Coordination Programs (LCCPs), and LPHAs) as necessary to fulfill CM

requirements. If the enrollee is not receiving CM from a subcontracted entity, the MCO shall perform all required CM activities for the enrollee/family.

- The MCO shall have processes in place to ensure that CM services provided by the Specialty Plan do not duplicate CM activities performed by its subcontracted CM entities.
- The MCO shall closely coordinate with Children's Division (CD) and Foster Care Case Management (FCCM), Division of Youth Services (DYS), Department of Mental Health (DMH) and other entities who may be providing case management activities to ensure that the Specialty Plan's CM program supports, but does not duplicate, activities performed by staff from CD, DYS, and other entities working with members/families/resource providers.
- The MCO shall minimize burden for enrollees, families, and resource providers to the greatest extent possible by working with other CM entities to develop shared assessments and care plans, and streamline points of contact to receive assistance in accessing needed services.
- The MCO shall have processes in place to monitor CM activities performed by the Specialty Plan and its subcontracted CM entities to ensure CM requirements are met. The MCO shall employ a quality improvement approach to evaluate and improve the efficiency, effectiveness and outcomes of its CM program for Specialty Plan enrollees.
- The MCO shall participate in an annual CM evaluation that is based on the Journey Mapping model.
- The MCO shall participate in and promote programs that provide consultative services that are beneficial to Specialty Plan members, including, but not limited to consultative services available through the Show-Me ECHO, University of Missouri Psychiatric Center (MUPC), Primary Care and CMHC Health Homes, the Center for Excellence in CHILD Well-Being (CFE), and Missouri's Child Psychiatry Access Project programs.

Specialty Plan CM Assignment:

- Upon enrollment, the MCO shall stratify and assign enrollees to an appropriate CM tier based upon the Specialty Plan's state agency-approved criteria and thresholds.
- The MCO shall perform an initial CM and disease management assessment within 14 calendar days of enrollment to identify the appropriate CM tier level and presenting issues necessary to start the formulation of the enrollee's care plan.
- The MCO shall re-evaluate an enrollee's tier assignment whenever there is a significant change in the enrollee's needs or risk factors, but no less than annually. Examples include an admission to an inpatient behavioral health setting, a newly diagnosed condition, a change in service utilization levels, and the prescription of a psychotropic medication or newly identified psychosocial need.

- The MCO's assignment methodology must consider the CM staff qualifications, experience, acuity mix, and the enrollee's cultural and linguistic needs.
- The MCO shall communicate the enrollee's tier assignment and Specialty Plan CM contact information to enrollees/families/resource providers, the enrollee's PCP, and all entities involved in performing CM activities and care planning.
- The MCO shall allow and consider requests from an enrollee/family/ resource provider, or an enrollee-serving system to assign the enrollee to a higher intensity tier of CM services.
- The MCO shall provide outreach to enrollees/families/resource providers to engage in CM. The MCO shall not terminate or close CM services for Specialty Plan enrollees/families/resource providers who do not respond to outreach attempts, do not engage in CM, or refuse CM services; however, the Specialty Plan may assign enrollees in those circumstances to the lowest intensity level of CM services. The MCO shall make reasonable outreach efforts prior to changing a member's tier to the lowest intensity level.

    - "Reasonable efforts" means either the enrollee/family/resource provider has refused CM services or the MCO has made at least three (3) different types of unsuccessful contact attempts. For enrollees in the legal custody of CD, prior to changing an enrollee's tier level to the lowest intensity level, the MCO shall contact the enrollee's CD case manager or FCCM case manager.
    - The MCO shall document contact attempts and CM refusals in the care plan.

d. _X_ **Treatment Plans**. For enrollees with special conditions who need a course of treatment or regular care monitoring, the State requires the MCO to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. _X_ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2. _X_ Approved by the MCO in a timely manner (if approval required by plan)

3. _X_ In accord with any applicable State quality assurance and utilization review standards.

RESPONSE:

MCO

Principles of Member CM - Services shall incorporate the following principles:

- A focus on enhancing and coordinating an enrollee's care across an episode or continuum of care; negotiating, procuring, and coordinating services and

resources needed by enrollees/families with complex issues, including but not limited to assessing enrollee needs related to social determinants of health (SDOH);

- Comprehensive care planning including stated enrollee/family-centered activities, measurable, defined goals, interventions and evaluation of progress;
- Provision of education to facilitate understanding of CM process;
- Application of clinical knowledge to the enrollee's qualifying condition to attain resolution, improvement or support during the CM process;
- Incorporation of shared goals meant to achieve improved quality, and clinical and cost outcomes, including appropriate utilization of resources and medical management;
- Inclusion of member/family education to help facilitate attainment of skills and resources needed to address enrollee/family goals;
- Promotion of preventative service utilization to help ensure quality outcomes for enrollees;
- Identification and planning interventions as needed to ensure appropriate utilization practices;
- Coordination of Transition of Care (TOC) efforts, whether the transition is movement through various health systems or health care payers;
- Incorporation of DM services if the qualifying event for DM is being managed along with other qualifying criteria;
- Promotion of the provision of CM by local, community-based care management entities;
- The MCO shall use a Section 2703 designated health home provider or LCCCP provider to perform CM services if the health home and LCCCP provider are members of the health plan network; and
- The MCO shall have processes in place to monitor service delivery to ensure that at least the minimum requirements for CM services are met.

CM Record Documentation – CM record documentation shall include, at a minimum, the following:

- How the member qualifies for CM outreach (e.g., tier assignment, disease process, behavioral health support, pregnancy, etc.);
- Referrals;
- Assessment/Reassessment;

- Medical history;
- Psychiatric history;
- Developmental history;
- Medical conditions;
- Psychosocial issues;
- Social determinants of health (e.g., housing, food insecurity, environmental impacts, etc.);
- Legal issues;
- Cultural and linguistic needs;
- Care Planning, which is shared with the PCP or designee and other health professional(s) involved in the enrollee's care and demonstrates a mechanism to allow for provider updates and communication with CM staff;
- Evidence of Care Plan updates at least quarterly and following any change to the Care Plan as a result of: enrollee/family touch, provider interaction, service utilization, and any other pertinent event;
- Testing, including results;
- Progress/contact notes;
- Discharge plans including changes or resources needed specific to the episode of care;
- Aftercare, including post-acute care needs;
- TOC coordination, which includes transitions between health care facilities as well as health care payers;
- Coordination/linking services;
- Monitoring of services and care;
- Follow-up;
- Evidence of preventative services promotion; and
- A listing of each distinct condition for which the member is being managed, including the start and stop date for each condition.

In addition to the requirements listed herein, the MCO shall screen and offer all pregnant enrollees for CM needs, including reimbursing healthcare providers according to the fee schedule when providers conduct such screenings and provide information to MO HealthNet's *Notification of Pregnancy (NOP) and Risk Assessment Portal*.

The requirements for contact and specific tasks include:

- When NOP information is not available for current or newly eligible members, the health plan shall offer CM within fifteen (15) business days of a notification or identification of pregnancy made by other means. For current members when NOP information is received, the

health plan shall offer CM services based upon MHD's NOP risk stratification scoring of physical, mental, and SDOH needs of the member, when available, according to the criteria below:

- Members deemed high (risk score between 35 and 49) and very high (risk score above 50) should receive initial outreach within three (3) business days of the health plan receiving the NOP data, excluding the day on which the NOP data was received, and three (3) outreach attempts should be made within five (5) business days.
- Members deemed moderate risk (risk score between 15 and 34) should receive initial outreach within five (5) business days of the health plan receiving the NOP data, excluding the day on which the NOP data was received, and three (3) outreach attempts should be made within ten (10) business days.
- Members deemed low risk (risk score below 15) should receive initial outreach within five (5) business days of the health plan receiving the NOP data, excluding the day on which the NOP data was received, and three (3) outreach attempts should be made within fifteen (15) business days.

- The initial CM and admission interaction shall include an assessment (face-to-face or telephone) of the member's needs. Initial outreach, follow-up materials, and member benefits related to pregnancy should be conducted in the member's preferred language as indicated on the NOP, consistent with the requirements described herein on availability of materials and translation services for prevalent non-English languages;
- A NOP form must be a part of the member's record. The health plan must use the state agency form. A submission form ID from the MHD portal may be substituted for the actual risk appraisal form, as it documents the health plan's receipt of the same information. Any other method for documenting the information from the NOP in the member's record is also acceptable. NOP submission status must be viewable by any health professional involved in the member's care.. These forms may be obtained from the *Physician Provider Manual* on the state agency's website, located at Provider Manuals | mydss.mo.gov;
- Outreach attempts must be made by multiple modes, e.g., by phone, text, e-mail, and/or U.S. postal mail, based on available participant information when a member is unreachable. Phone calls must be placed by health plan staff (not robo-calls), at different times of the day, and on different days of the week;
- For high or very high risk members who are unable to be reached to offer CM services during the initial outreach phase of five (5)

business days, the health plan must communicate this fact directly to the OB provider team and request assistance in connecting with the member. The member's OB provider team should be able to view the CM outreach history in the provider portal or equivalent method, or alternatively the health plan should summarize outreach history to OB providers of high or very high risk members upon their request. Coordination of Care between the provider and CM manager must be completed by the CM team of the health plan;

- The sharing of care plans with health professionals involved in the member's care, as described herein, shall include communication to the provider who submitted the *NOP and Risk Assessment* information in the state's portal. This requirement may be satisfied by having practitioner or provider portals, or equivalent method, that have accessible patient-specific data including the care plan. Health plans must offer quarterly OB-specific trainings to all providers who have submitted NOPs in the most recent quarter regarding how they can use the provider portal or equivalent method to access patient-specific data including care plans and CM activity. Health plans must have an option for providers or their teams to elect to receive notifications regarding CM activity. Complying with the above criteria satisfies the sharing of care plans requirement for pregnancy CM;
- Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Use Treatment Referral Protocol for Pregnant Women Under the Managed Care Program;
- Referrals to prenatal care (if not already enrolled), within two weeks of enrollment in CM;
- Referral to a dental provider for an annual dental visit (if not already scheduled), within six weeks of enrollment in CM;
- Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one week of the appointment with documentation indicating why the appointment was broken. This information could potentially be used for identifying trends through a root cause analysis process to determine if intervention could improve outcomes;
- Methods to ensure that EPSDT/HCY screens are current if the member is under age 21;
- Referrals to WIC (if not already enrolled), within two weeks of enrollment in CM;
- Assistance in making delivery arrangements by the 24th week of gestation;

- Assistance in making transportation arrangements for prenatal care, delivery, and post-partum care;
- Referrals to prenatal or childbirth education where available;
- Assistance in planning for alternative living arrangements which are accessible within 24 hours of those who are subject to abuse or abandonment;
- Assistance to the mother enrolling the newborn in ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with a Managed Care Program application for the child, if needed;
- Assistance in identifying and selecting a medical care provider for both the mother and the child;
- Identification of feeding method for the child;
- Notification to current health care providers when CM services are discontinued and why services are discontinued;
- Referrals for family planning services if requested; and
- Directions and supplemental education to members to start taking folic acid vitamins prior to next pregnancy.

- In addition to the requirements listed above, the MCO shall ensure CM activities include the following services in the care plans for children with elevated blood lead levels.

    - Ensure confirmation of capillary tests using venous blood according to the timeframe listed below:

        - 3.5-9 μg/dL – within three (3) months;
        - 10-44 μg/dL – within one (1) month;
        - 45-59 μg/dL – within 48 hours;
        - 60-69 μg/dL – within 24 hours; and
        - >70 μg/dL – immediately as an emergency test.

    - Ensure that the Childhood Blood Lead Testing and Follow-Up Guidelines are followed as required:

        - 3.5-9 μg/dL – Early follow-up testing – within three months, with later follow-up testing after BLL declining six to nine months;
        - 10-19 μg/dL - Early follow-up testing – within one to three months, with later follow-up testing after BLL declining in one to three months;

- 20-24 μg/dL – Early follow-up testing – within one to three months, with later follow-up testing after BLL declining in one to three months;

- 25-44 μg/dL – Early follow-up testing within two weeks to one month, with later follow-up testing after BLL declines to one month; and

- >45 μg/dL – Immediate follow-up notification of DHSS required. Early follow-up of BLL of 45-69 μg/dL requires STAT venous confirmation and receipt of the result before chelation therapy is administered.

- Early follow-up for BLL >70 μg/dL requires STAT venous confirmation before chelation, but chelation should commence prior to receipt of the result, at the end of chelation, seven days after chelation and 21 days after chelation.

- Ensure a minimum of two (2) enrollee/family encounters are conducted by face-to-face or video conference. Initial visit must be performed within two (2) weeks of receiving a confirmatory blood lead level that meets the lead case management requirements. This visit must include the following:

  - An enrollee/family assessment;
  - Provision of lead poisoning education offered by health care providers;
  - Engagement of enrollee/family in the development of the care plan; and
  - Delivery of the case manager's name and telephone number.

- Ensure a follow-up visit or second (2^{nd}) encounter within three (3) months following the initial encounter is made. Assessment and review of the child's progress, parental compliance with recommended interventions, reinforcement of lead poisoning education, enrollee education, and the medical regimen should be performed at that time.
- When the child receives a BLL below 3.5 ug/mL, the health plan shall complete an exit evaluation and consider the child for case closure. This encounter must include, at a minimum, discharge counseling regarding current BLL status, a review of ongoing techniques for prevention of re-exposure to lead hazards, as well as nutrition, hygiene, and environmental maintenance. This contact may occur via telephone, video conference or in person by the care manager.

- A discharge from BLL case management may take place on an existing lead case after the case has been open for a minimum of one calendar year when the health plan is unable to contact the member. The health plan must make at least three different types of attempts (home visit, sending letters with an address correction request, checking with the PCP, WIC, and other providers and programs) to contact the member/family to conduct an exit evaluation/case closure. All attempts to contact must be documented in the DHSS database along with the reason for closure. Notification of the closure must be sent to the member/family and PCP with instructions for contacting the health plan to resume care management activities.

- The following should be documented in the enrollee's record:

  - Initial visit: The admission progress note must document contact with the child's PCP and any planned interventions by the MCO or subcontractor care manager. The notes must also include the plan of care and include, at a minimum, blood lead level/s, assessment of the enrollee/family including resulting recommendations, and lead poisoning education that includes acknowledgement of parental understanding of this education.
  - The MCO must use the database utilized by DHSS to document lead case management activities. The MCOs may use the DHSS Childhood Lead Poisoning Prevention Program Nurse's Lead Case Management Questionnaire and the Nutritional Assessment forms to assist them in capturing all the required case management elements for documentation. Both forms are found in the *Lead Poisoning Prevention Manual* at http://health.mo.gov.
  - Follow-up visit(s): The documentation must include the most recent laboratory results, enrollee status, any interventions by care manager, contacts with the child's primary care provider and progress made to meet plan of care goals.
  - Exit evaluation/ case closure contact: The discharge documentation must include the date of discharge, reason for discharge, lab results, enrollee status, and exit counseling. The exit counseling documentation must include a telephone number for enrollee questions and assistance, and status of plan of care goal completion. The documentation must include enrollee/family and primary care provider notification of discharge from case management and continued care coordination plan.

Care Management Closure:

The MCO must have criteria for terminating care management services. These criteria shall be included in the care plans. Acceptable reasons for case closure for care management (excluding care management for elevated lead levels) include:

- Achievement of goals stated in care plan including stabilization of the enrollee's condition, successful links to community support and education, and improved member health;
- Enrollee request to withdraw from either care management or the MCO;
- Lack of contact with the care manager or lack of compliance with care management must be documented in the care plan. At least three (3) different types of attempts to locate and engage the enrollee should be made to contact the family prior to closure for this reason. Where appropriate, these should include attempts to contact the member's family. Examples of contact attempts include:

    - Making telephone call attempts before, during, and after regular working hours;
    - Visiting the family's home;
    - Sending letters with an address correction request; and
    - Checking with primary care provider, Women, Infants, and Children (WIC), and other providers and programs.

- The MCO must review cases for closure from prenatal care management no sooner than sixty (60) days from the date of delivery;
- For children receiving care management due to elevated blood lead levels, the MCO must review cases for closure using the following occurrences:

    - When current blood lead level is less than 3.5 ug/dL; or
    - When the child is disenrolled and referral to a new health plan, local public health agency, or health care provider has been completed.

- The PCP must be notified in writing of all instances of children discharged from care management and the reason for discharge. The discharge notification must include a history of the child's condition.
- The health plan shall provide quarterly and yearly outcome measurement and reporting. The reporting requirements specified herein will satisfy this component.

In addition to the requirements above, the MCO of the Specialty Plan shall:

- Document MCO subcontracted entities or other persons performing CM activities.

- Outreach to enrollees/families/resource providers to engage in care coordination;
- Conduct or arrange for enrollee assessments as needed;
- Offer health education, DM, and wellness/prevention coaching;
- Facilitate case conferences and develop multidisciplinary, shared care plans that include crisis/safety plans as appropriate;
- Educate providers about resources available through Missouri's Child Psychiatry Access Project, MUPC, the Center for Excellence in CHILD Well-Being, and regional/county-specific child welfare and juvenile resources;
- Coordinate enrollee access to services and resources identified in the care plan, including securing necessary authorizations and identifying network providers to deliver services;
- Educate enrollees/families/resource providers about covered benefits and screening/referring members/families/resource providers to community resources for psychosocial (social determinants of health) needs;
- Collaborate, communicate, and exchange information with PCPs, providers, and other enrollee-serving entities, as permitted by state and federal law, to coordinate member care;
- Coordinate services that are not included in the Specialty Plan's comprehensive benefit package, but are covered by other member-serving entities;
- Ensure enrollees receive services needed for permanency planning;
- Monitor to ensure that care plan services are delivered and the effectiveness of services;
- Participate in discharge planning activities to prevent unnecessary readmissions, emergency room visits, and other adverse outcomes; and
- Facilitate transitions of enrollees' care.

e. **X** **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

RESPONSE:

MCO

The state requires MCOs to allow enrollees with disabling conditions or chronic illnesses to request that their PCPs be specialists. Depending on the nature of the enrollee's disabling condition or chronic illness, the enrollee may request their

PCPs be specialists such as a psychiatrist, oncologist, obstetrician, gynecologist, or other such specialists. MCOs are required to have procedures for ensuring access to needed services for these enrollees.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

RESPONSE:

Items (a) through (f) are not applicable to ToRCH as an HRSN/PCCM model that focuses on community-level strategy. Please see Items (g), (h), and (i).

a. n/a_ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. n/a Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. n/a_ Each enrollee receives **health education/promotion** information. Please explain.

d. n/a_ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. n/a_There is an appropriate and confidential **exchange of information** among providers.

f. n/a_ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g._**X**_ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

RESPONSE:

ToRCH community strategies allow PCP case managers to more effectively and comprehensively identify barriers that hinder enrollee compliance with prescribed treatments or regimens, for example, by identifying transportation insecurity that creates a barrier to attending community-led and/or group therapy sessions, or housing insecurity that affects someone's asthma and triggers avoidable trips to the

ED. The referral platform allows such identified barriers to be addressed systematically.

h. **_X_ Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

RESPONSE:

ToRCH utilizes a Community Information Exchange platform to allow referred services to be documented by the PCP case manager or staff and to monitor whether the patient received the referred services and in what timeframe. All primary care partners in the ToRCH community have access to the platform and can view their patients' records and prior referrals by other clinics.

i. **_X_ Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners and documented in the primary care case managers' files.

RESPONSE:

ToRCH utilizes a Community Information Exchange platform to allow referred services to be documented by the PCP case manager or staff as they conduct the HRSN screening. The staff person is able to check for services in real time, screen for eligibility to receive services without cost, ask the patient if this is acceptable, and send a notification of the patient's need to the community organization to address. They can then monitor whether the patient received the referred services and in what timeframe. All primary care partners in the ToRCH community have access to the platform and can view their patients' records and prior referrals by other clinics.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part III: Quality

1. **Assurances for MCO program**.

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 and these contacts are effective as follows:

RESPONSE:

MCO

MO HealthNet Managed Care contracts were effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Contracts will be submitted to CMS upon award.

_X_ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs. The State assures CMS that this **quality strategy** was submitted to the CMS Regional Office in CY 2024.

RESPONSE:

The Quality Improvement Strategy and evaluation of the previous strategy are located on the state's website at https://dss.mo.gov/mhd/mc/pages/quality-oversight.htm.

X The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO contract. Please provide the information below (modify chart as necessary)

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	Comagine Health		Validation of performance improvement projects	
MCO	Comagine Health		Validation of MCO performance measures	
MCO	Comagine Health		Compliance Review	
MCO	Comagine Health		Information Systems Capabilities Assessment	
MCO	Comagine Health		Network Adequacy Validation	
MCO	Comagine Health			Care Management Record Review
MCO	Comagine Health			Provider Directory Secret Shopper Survey for Managed Care

Missouri awarded the external quality review contract to Comagine Health for services beginning January 1, 2024. Effective January 1, 2024.

2. **Assurances For PAHP program.**

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the

managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

RESPONSE:

Items (a) and (b) are not applicable to ToRCH as a HRSN/PCCM model that focuses on community-level strategy. Please see Items (c) and (d).

a. _ n/a _The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. _ n/a _**State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1.___ Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3.___ Request PCCM's response to identified problems;

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7.___ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. __X__ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ___ Initial credentialing

B. ___ Performance measures, including those obtained through the following (check all that apply):

___ The utilization management system.
___ The complaint and appeals system.

___ Enrollee surveys.
___ Other (Please describe).

4. __X__ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

   RESPONSE:

   Each applicant is scored (up to 100 points) on their Preparation, Approach, and Implementation Plan based on the following criteria:

   - Leadership Board (12 pts)
   - Community Partners (12 pts)
   - Knowledge of CBOs (8 pts)
   - Population Health Goals (16 pts)
   - Data sharing (8 pts)
   - Readiness and Commitment (20 pts)
   - Narrative (24 pts)

   We anticipate adding a new cohort of ToRCH entities every two-three years until all interested and qualifying rural entities are part of the model.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ___ Other (please describe).

d. __X__ **Other quality standards** (please describe):

Once selected, ToRCH entities must maintain quality and performance standards to be able to continue participating in the program. Implementation standards include:

- 100% of ToRCH clinical and CBO partners have completed onboarding documentation and requirements;

- 90% of identified ToRCH end-users participate in at least one engagement or training activity prior to going live;
- 80% of users activate their CIE platform account within the first 14 calendar days of the start date.

In each quarter, participation targets shall be met, including: (1) referral activity representing increasing percentages of the Medicaid participants in the ToRCH county over the first two years, with at least 80% referral acceptance rate and 70% case resolution rate; (2) analysis of SDOH/referral data against claims and clinical data from the prior quarter; (3) monitored CBO partners; (4) participated in learning collaborative and other technical assistance.

Other quality measures will be monitored within participating hospitals to ensure that the goals of the program are being met and that no necessary utilization is inappropriately restricted. The MO HealthNet Division currently monitors a variety of quality and performance measures in the managed care program, most notably a performance withhold which includes 12 different Healthcare Effectiveness Data and Information Set (HEDIS) measures. Participation and a focus on quality health outcomes by rural hospitals and the providers they employ is paramount in order for these goals to be met. Rural hospitals and providers are poised to earn provider incentives from Managed Care Organizations based on their performance on these same metrics, including but not limited to, Well-Child Visits, Childhood Immunizations, Prenatal and Postpartum Care, and Follow-Up After Hospitalization for Mental Illness. Percentage point improvements must be realized for payment to be dispersed in the performance withhold. A Technical Specifications document can be found online at https://mydss.mo.gov/media/pdf/mhd-managed-care-performance-withhold-technical-specifications.

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO administrator marketing (e.g., radio and TV advertising for the MCO in general) and direct MCO marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

_X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts were effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Contracts will be submitted to CMS upon award.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**

A. **Scope of Marketing**

1. _X_ The State permits indirect marketing by MCO providers (e.g., radio and TV advertising for the MCO in general). Please list types of indirect marketing permitted.

RESPONSE:

MCO

Indirect marketing materials permitted for the MO HealthNet Managed Care Program include, but are not limited to, radio, television, MCO websites, including web videos, social media (e.g., Facebook, Twitter, etc.), YouTube, cell phone texting, email, newspaper, yellow page advertising, billboards, mass mailings, community health fairs, and special events. The state monitors indirect marketing materials.

2. _X_ The State permits direct marketing by MCO (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

RESPONSE:

MCO

The state does not permit MCOs to directly market to all MO HealthNet participants. The direct marketing types that are permitted for the MO HealthNet Managed Care Program include, but are not limited to: physician network mailings to patients informing them of the MCO affiliation; MCO mailings to MO HealthNet Managed Care enrollees informing them of health fairs, community, and special events; and MCO newsletters.

B. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. _X_ The State prohibits or limits MCOs from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

RESPONSE:

MCO

The state monitors the offering of gifts or other incentives by the MCOs' at community activities through a written process and a written proof of cost per unit. The value of the gift can be no greater than $15. The gifts must be directly and obviously health related or limited to printed materials, t-shirts, pens or pencils, caps, mugs, key chains, etc. Advertising the availability of such gifts through

mailings, TV or radio spots, posters, and other promotions or publicity is prohibited.

2.___ The State permits MCOs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. **X** The State requires MCO to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

RESPONSE:

MCO

The MCOs must make their written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in their particular service area. Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost. Language assistance to potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English. Written materials must include taglines in the prevalent non-English languages in the state, as well as be printed in a conspicuously visible font size, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the health plan. A list of the top 15 languages spoken by individuals with limited English proficiency identified for the state of Missouri is found at: https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/top15-languages/index.html?languages.

ToRCH

ToRCH sites must make any written materials they create to communicate the effort to Medicaid participants in all of the prevalent languages in their service area, i.e., the county or counties in which the site operates.

The State has chosen these languages because (check any that apply):

i. **X** The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

RESPONSE:

Missouri uses the 15 prevalent non-English languages as identified by the U.S. Department of Health and Human Services for Missouri.

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

_X_ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts are effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Contracts will be submitted to CMS upon award.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.**

a. **Non-English Languages**

_X_ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as: (check any that apply):

1. _X_ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

RESPONSE:

Missouri uses the 15 prevalent non-English languages as identified by the U.S. Department of Health and Human Services for Missouri.

2. ___ The languages spoken by approximately __ percent or more of the potential enrollee/ enrollee population.

3. ___ Other (please explain):

_X_ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

RESPONSE:

MCO

The enrollment broker, through the enrollment packet, notifies all enrollees that oral translation services are available by calling the MO HealthNet Managed Care Enrollment Helpline. The enrollment broker utilizes TeleInterpreters powered by Language Line for oral translation services. The enrollment broker also utilizes bi-lingual, Spanish speaking enrollment counselors. Relay Missouri is utilized for the hearing impaired. Relay Missouri is a service that provides full telephone accessibility to people who are deaf, hard of hearing, deaf-blind, and speech disabled. These services are available 24 hours a day, seven days a week and there is no charge for anyone to use. Equipment itself is available upon request to eligible parties. This service is funded by the state.

The MCOs provide interpreter services as necessary by telephone or in person to ensure that enrollees are able to communicate with the MCO.

_X_ The State will have a **mechanism** in place to help enrollees understand the managed care program. Please describe.

RESPONSE:

MCO

The enrollment broker provides each enrollee an enrollment packet that contains an informational brochure on the MO HealthNet Managed Care Program including its benefits and use, responsibilities, and the MCOs available. A toll-free enrollment help line is available 7 a.m. to 6 p.m., Monday through Friday except for holidays. Trained enrollment counselors educate enrollees who call the MO HealthNet Managed Care Enrollment Helpline on the MO HealthNet Managed Care Program benefits and use. The informational brochure is available on the state's website at https://dss.mo.gov/mhd/pdf/managed-care-guide.pdf.

The MCOs, through trained member services staff, educate enrollees about the operation of the MCO and covered benefits. The toll-free member services line is available at least nine consecutive hours during the hours of 7:00 a.m. through 7:00 p.m., Monday through Friday except for holidays. The MCOs also provide member materials and information through their websites.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_-_ State will promote new programs through website and social media.

__ contractor (please specify)

___ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

RESPONSE:

MCO

The participants are automatically assigned to an MCO the day they are deemed eligible for MO HealthNet Managed Care benefits. Therefore, no information is provided to potential enrollees.

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) _**X**_ the State will promote through website and social media.

(ii) _X_ State contractor (please specify): Effective July 1, 2022, Wipro Infocrossing is the enrollment broker until the implementation of Automated Health Services (AHS) as the new enrollment broker during the 2nd Quarter of State Fiscal Year 2023.

(iii) _X_ the MCO

C. Enrollment and Disenrollment

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

_X_ The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts were effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Contracts will be submitted to CMS upon award.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. _X_ **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the

outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

RESPONSE:

MCO

The state requires the enrollment broker to provide ongoing outreach for the purpose of providing an understanding of MO HealthNet Managed Care, how it works, its benefits, and to assist the MO HealthNet Managed Care enrollee to make informed decisions. The enrollment broker develops and provides outreach materials to MO HealthNet Managed Care enrollees throughout the state. If required by the state, the enrollment broker conducts community outreach group presentations. All outreach materials are monitored by the state. The state also operates a website for enrollees to enroll online.

Ombudsmen Outreach Efforts

The four Legal Service entities provided outreach to Missouri citizens as detailed below.

Eastern Region

Legal Services of Eastern Missouri serves 21 counties and made presentations to the following groups/organizations and provided MO HealthNet Managed Care information and brochures during the end of 2020 and the beginning of 2021 (June-December 2020 and January-June 2021).

- Washington County Partnership Meeting
- Asthma & Allergy Foundation
- Our Lady's Inn
- Great Mines Health Center
- Missouri Foundation for Health
- Gateway to Hope

Central Region

Mid-Missouri Legal Services serves 11 counties and made presentations to the following groups/organizations and provided MO HealthNet Managed Care information and brochures during the end of 2020 and the beginning of 2021 (June-December 2020 and January-June 2021):

- Residents participating in UMC Children's Hospital CARE rotation
- Quality Assessment and Improvement Advisory Group

- Home State
- Healthy Blue
- UHC (United Healthcare)
- Quarterly Meeting with MO HealthNet
- MO HealthNet Division
- Family Support Division
- Kids Win Missouri
- Anthem
- Cover Missouri Medicaid Advisory Group

Western Region

Legal Aid of Western Missouri serves 40 counties and made presentations to the following groups/organizations and provided MO HealthNet Managed Care information and brochures during the end of 2020 and the beginning of 2021 (June-December 2020 and January-June 2021):

- Healthcare Collaborative of Rural Missouri: Odessa Project Connect
- Healthcare Collaborative of Rural Missouri: HCC Member Network Meeting
- LAWMO Virtual Office Hours
- Missouri Primary Care Association: Open Enrollment Training
- Virtual Office Hours – Mpower
- HCC Membership Meeting – Health Care Collaborative of Rural Missouri
- Homeless Youth & Medicaid Applications – KC Care/Homeroom Health
- Career Week – Brookside Charter
- Cover KC Meeting
- Operation Breakthrough Staff Meeting
- Health Services Advisory Committee Meeting – MARC
- One-On-One Contact with Provider – Haywood Hambrick DDS
- Medicare Training – CLAIM
- 5th Annual Greater KC Community Baby Shower – Fedex Ground, Home State Health, KFC; Presented By: Jazzie Cares Foundation
- Lexington Project Connect – LiveWell; HCC: Reach Healthcare Foundation; West Central Electric Roundup Foundation
- KWM Monthly Update: Missouri Legal Services Presentation – Kids Win Missouri
- Heart to Help Drive Thru Event – LT University Program/KC Kindness Neighborhoods and Housing Services Department
- Odesa Project Connect – Health Care Collaborative of Rural Missouri.

Legal Services of Southern Missouri

Legal Services of Southern Missouri serves 43 counties and made presentations to the following groups/organizations and provided MO HealthNet Managed Care information and brochures during the end of 2020 and the beginning of 2021 (June-December 2020 and January-June 2021).

- Medicaid Advisory Meeting
- United Health Care Tri-Annual Meeting
- Tri-Annual Meeting with Legal Service Providers
- Medicare Advisory Group
- FSD Meeting
- Legal Advocacy Meeting
- Cover Mo Meeting
- Monthly FSD Legal Services
- Tri-Annual Meeting
- Kids Win
- Home State Health Plan for Family Advocates Triannual Meeting
- Advocates for Family Health

b. **Administration of Enrollment Process**.

___ State staff conducts the enrollment process.
__X__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

__X__ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Effective February 20, 2023, Automated Health Services (AHS) is the enrollment broker for MCO enrollees. Previously, Wipro Infocrossing was the enrollment broker for MCO enrollees, effective July 1, 2022, to February 19, 2023.

Please list the functions that the contractor will perform:

__X__ choice counseling
__X__ enrollment
___ other (please describe):

___ State allows MCO to enroll beneficiaries. Please describe the process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

_**X**_ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

RESPONSE:

ToRCH: Implemented in each of six pilot sites at once at the start of the program; anticipate amending waiver to add a similar number of additional sites in 2-3 years.

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

_**X**_ If a potential enrollee **does not select** an MCO within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. _**X**_ Effective July 1, 2022, Children in State Custody will be auto-assigned to the Specialty Plan MCO the same day they are determined eligible for MO HealthNet and will not be allowed to change their MCO at any time.

Effective July 1, 2022, enrollees, except for Children in State Custody, will be auto-assigned to an MCO the same day they are determined eligible for MO HealthNet and allowed ninety (90) days to change their MCO.

ii. _**X**_ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO who is their current provider or who is capable of serving their particular needs.

RESPONSE:

MCO

The auto-assignment algorithm assigns enrollees as follows:

a. If the MO HealthNet Managed Care enrollee is enrolled with an MCO, the enrollee shall continue with their current health plan unless that health plan is no longer offered. If not, the next step in the algorithm will be followed.

b. If the MO HealthNet Managed Care enrollee is included in a MO HealthNet eligibility case where another enrollee is enrolled with an MCO, the MO HealthNet Managed Care enrollee shall be assigned to

that MCO. If not, the MO HealthNet Managed Care enrollee will be assigned randomly as outlined in the remainder of the section.

c. If an MCO has fifty-five percent (55%) of the regional membership or greater, regional auto-assignment into the MCO will be limited to enrollees meeting the algorithm criteria for only items (a) and (b) above.

d. If one MCO has less than twenty percent (20%) of the regional membership or 25,000 members, whichever is greater, that MCO will receive one hundred percent (100%) of the auto-assigned membership following the application of the algorithm criteria for items (a) and (b) above.

e. If multiple MCOs have enrollment below twenty percent (20%) of the regional membership or 25,000 members, whichever is greater**,** 100% of the auto-assignments, following the application of the algorithm criteria for items (a) and (b) above, will be shared equally among the MCOs with less than twenty percent (20%) of the regional membership or 25,000 members, whichever is greater. The MCO with the highest evaluation score (determined by the State of Missouri) will receive the first member.

f. If all MCOs have at least twenty percent (20%) or 25,000 members, whichever is greater, and less than fifty-five percent (55%) of the membership within each region, the MCOs shall equally share in the allocation from the auto-assignment process following the application of the algorithm criteria for items (a) and (b) above.

g. The enrollment percentage by MCO and by region will be calculated on a monthly basis. If the enrollment percentage by MCO and by region necessitates a change in the auto-assignment algorithm, the change will be implemented on the first business day of the following month and will remain in effect until the enrollment percentages trigger another change in the application of the auto-assignment algorithm. Actual enrollment will be determined based on each MCO's enrollment market share during the last week of each month and reported to each MCO.

All enrollees assigned to a General Plan MCO have a 90-calendar-day change period to determine if the MCO selected meets their needs. During this change period, they can transfer to another MCO without cause. Children in state custody may not change their MCO as they are automatically enrolled into a single health plan (Specialty Plan) per the 1115 Waiver Expenditure Authority approved by CMS June 10, 2022.

To ensure that the MCOs meet the needs of persons with special health care challenges, the state has developed and implemented policies that emphasize uninterrupted care. Special attention has been given to the transition of care from Fee-for-Service to MO HealthNet Managed Care. For example, prior to discontinuing any personal care services, the MCO must work with the state to evaluate the continuing needs of the enrollee. Notification of enrollees participating in the DD Waiver is also provided to the MCOs. MCOs receive the MO HealthNet Health Risk Assessment completed by their enrollees.

The state continues to focus its attention on special health care needs populations. In order to capture the special health care needs population, the state implemented a monthly report during January 2000. This report identifies the MCOs' new enrollees that fall within one of the following special needs categories: Individuals eligible for Supplemental Security Income (SSI); individuals in foster care or other out-of-home placement; individuals receiving foster care or adoption subsidy; and individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state in terms of either program participant or special health care needs.

_X_ The State **automatically enrolls** beneficiaries

___ on a mandatory basis into a single MCO in a rural area (please also check item A.I.C.3)

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO enrollees under the State plan.

_X_ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

RESPONSE:

MCO

If an enrollee is eligible for SSI under Title XVI of the Social Security Act, described in Sections 501(a)(1)(D) and 1902(e)(3) of the Social Security Act, or meets the SSI disability definition as determined by the state, the enrollee is eligible for exemption from enrollment at any time. The enrollee may choose not to enroll or disenroll. They may enroll at a later time.

If the enrollee requests an exemption from enrollment, the enrollment broker will verify that the enrollee is eligible for an exemption as described above. When verification is made, the enrollee is disenrolled from the MCO within three days.

Enrollees who meet the medical definition of SSI must have their physician complete a form attesting to the disability. Upon receipt and evaluation of the form by the state, the enrollee is disenrolled from the MCO within three days.

X The State **automatically re-enrolls** a beneficiary with the same MCO if there is a loss of Medicaid eligibility of 2 months or less.

RESPONSE:

The state will automatically enroll members who are disenrolled from an MCO due to loss of eligibility into the same MCO and to the same primary care provider should they regain eligibility within ninety calendar days. The member will have ninety calendar days from the effective date of coverage with the MCO in which to change MCOs for any reason.

Additionally, the state automatically enrolls members who move from one region to another into the same MCO.

d. **Disenrollment:**

X The State allows enrollees to **disenroll** from/transfer between MCOs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. **X** Enrollee submits request to State.

ii. __ Enrollee submits request to MCO. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.__ Enrollee must seek redress through MCO grievance procedure before determination will be made on disenrollment request.

RESPONSE:

MCO

Enrollees have the following good cause reasons for disenrollment:

- The enrollee requests a transfer during open enrollment.
- The enrollee requests a transfer during the first 90 days enrolled in the MCO.
- Transfer is the resolution to a grievance or appeal.
- The PCP or specialist with whom the enrollee has an established patient/provider relationship does not participate in the MCO they are currently enrolled in, but does participate in another MCO.
- The enrollee is pregnant and her PCP or OB/GYN does not participate in the MCO, but does participate in another MCO.
- The enrollee is a newborn, and the PCP or pediatrician selected by the mother does not participate in the MCO, but does in another MCO.
- Transfer to another MCO is necessary to ensure continuity of care.
- An act of cultural insensitivity that negatively impacts the enrollee's ability to obtain care and cannot be resolved by the MCO.
- The enrollee had an address change and did not receive an enrollment packet. As a result, the enrollee was randomly assigned to the MCO.
- A special health care needs enrollee (Title V, SSI and foster care) requests a different MCO with the approval of the state.
- Any individual receiving SSI, or who meets the medical definition for SSI benefits, may voluntarily disenroll at any time.
- Transfer to another health plan is necessary to correct an error made by the enrollment broker or the state agency during the previous assignment process.
- May also request a transfer in order for all family members to be enrolled with the same health plan.

___ The State **does not have a lock-in**, and enrollees in MCOs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

__X__ The State permits **MCOs to request disenrollment** of enrollees. Please check items below that apply:

i. __X__ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

RESPONSE:

MCO

The MCO may request that an enrollee be disenrolled, subject to the conditions described below:

a. The MCO may not initiate disenrollment because of a medical diagnosis or health status of an enrollee. MCOs may not request disenrollment because of the enrollee's attempt to exercise his or her rights under the grievance system, pre-existing medical conditions, high-cost medical bills, anticipated need for health care, or behaviors resulting from a medical or mental illness/disorder.
b. A persistent refusal of the enrollee to follow prescribed treatments or comply with MCO requirements that are consistent with state and federal laws and regulations.
c. Consistently missed appointments without prior notification to the provider.
d. Fraudulent misuse of the MO HealthNet Managed Care Program, and abusive, or threatening conduct.
e. Request for a home birth.
f. The MCO must be able to demonstrate by medical record documentation attempts through education and case management to resolve any difficulty leading to a request for disenrollment at least three times over a period of 90 days before requesting disenrollment or transfers, unless the enrollee has demonstrated abusive or threatening behavior, in which case only one attempt is required. The MCO must cite at least one example of good cause before requesting the state to disenroll the enrollee. If the MCO intends to proceed with disenrollment during the 90-day period, a notice citing the appropriate reason must be given to both the enrollee and the state at least 30 days before the end of the 90-day period. All notifications regarding requests for disenrollment must be documented.
g. Enrollees will have the right to appeal an MCO-initiated disenrollment to both the state and the MCO through the appeal process within 90 days of the MCO's request to the state for asking to disenroll the enrollee. When an enrollee files an appeal, the appeal process must be completed prior to the MCO and state continuing disenrollment procedures.
h. Within 15 working days of the final notification (after no appeal or a final hearing decision), enrollees will be enrolled in another MCO or transferred to another provider.
i. MCOs that recommend disenrollment or transfers for reasons

other than these may be subject to sanction by the state.

The state has sole authority for disenrolling enrollees from MCOs. When an enrollee is transferred to or from an MCO, the MCO must have written policies and procedures for timely transfer of relevant patient information including medical records or other pertinent materials. For enrollees with behavioral health or substance use disorders, the state will look for documentation of the disorder and what interventions have taken place through treatment, case management, and care coordination with other health care providers. Prior to granting any MCO requested disenrollment, the state carefully reviews all requests to ensure the behavior that is instigating the disenrollment request is not the result of a medical or mental disorder.

ii. **X** The State reviews and approves all MCO-initiated requests for enrollee transfers or disenrollments.

iii. **X** If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO to remove the enrollee from its membership or from the MCO's caseload.

iv. **X** The enrollee remains an enrollee of the MCO until another MCO is chosen or assigned.

D. Enrollee Rights.

1. **Assurances.**

X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts are effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Initial contracts will be submitted to CMS upon award.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

X The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs**. States, MCOs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
   b. ensuring that enrollees may request continuation of benefits during a course of treatment, during an appeal or reinstatement of services if the state takes action without the advance notice and as required in accordance with state policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
   c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

   X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO program**. MCOs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

   X The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

   ___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a

waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts are effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Initial contracts will be submitted to CMS upon award.

3. **Details for MCO program**.

a. **Direct access to fair hearing**.

_X_ The State **requires** enrollees to **exhaust** the MCO grievance and appeal process before enrollees may request a state fair hearing.

___ The State **does not require** enrollees to **exhaust** the MCO grievance and appeal process before enrollees may request a state fair hearing.

RESPONSE:

The State requires enrollees to exhaust the MCO grievance and appeal process before requesting a state fair hearing pursuant to new federal regulations.

b. **Timeframes**

_X_ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is _60_ days (between 20 and 90).

___ The State's timeframe within which an enrollee must file a **grievance** is __ days.

RESPONSE:

MCO

The state's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an appeal is 60 calendar days from the date the health plan's notice of adverse benefit determination.

An enrollee may file a grievance, either orally or in writing, at any time.

c. **Special Needs**

___ The State has special processes in place for persons with special needs. Please describe.

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

__X__ The State has a grievance procedure for its __X__ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

___ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

___ Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

___ Establishes and maintains an expedited review process for the following reasons: _____. Specify the time frame set by the State for this process____

___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

___ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

__X__ Other (please explain):

RESPONSE:

The ToRCH model has an oversight structure that includes a State Advisory Committee as well as Community Leadership Boards at each site. Any grievances or appeals from ToRCH partners (clinical or community) or from Medicaid participants are initiated at the Community Leadership Board. These groups meet monthly and will address such matters on that cadence. Any grievances or appeals that cannot be resolved at the Leadership Board level will be escalated to MO HealthNet ToRCH staff. The concern will be addressed promptly by MO HealthNet staff but can also be routed to the State Advisory Committee for review and guidance prior to a decision being made. The individual or organization making the grievance or appeal will be notified in writing as to the decision. Individuals who request 1915(b)(3) services and are denied access to services will be able to use the state fair hearing system.

F. Program Integrity

1. **Assurances.**

__X__ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition

Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO;
(2) A person with beneficial ownership of five percent or more of the MCO's equity;
(3) A person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the State.

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances For MCO program.**

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

X State payments to an MCO are based on data submitted by the MCO. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for the MCO program. Please identify each regulatory requirement for which a waiver is requested, the managed

care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO.

RESPONSE:

MCO

MO HealthNet Managed Care contracts are effective July 1, 2022, through June 30, 2023. Four additional one-year renewal periods began July 1, 2023. Initial contracts will be submitted to CMS upon award.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the state itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality

strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern Fee-for-Service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

MCO RESPONSE:

The chart was deleted from this document and placed in Appendix B, Part I Monitoring Activities Chart. (Tab 1)

ToRCH RESPONSE:

The chart was deleted from this document and placed in Appendix B, Part I Monitoring Activities Chart. (Tab 2)

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ___ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

b. _**X**_ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

_**X**_ NCQA
___ JCAHO
___ AAAHC
_X__Other (please describe) – Utilization Review Accreditation Commission (URAC)

RESPONSE:

The MCOs are required to obtain MCO accreditation, at a level of "accredited" or better, for the MO HealthNet product from NCQA or URAC. The MCO shall maintain such accreditation and throughout the duration of the contract.

Failure to obtain accreditation at a level of "accredited" and failure to maintain accreditation thereafter shall be considered a breach of the contract and shall result in termination of the contract in accordance with the terms of the contract. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the Final Report and may result in termination of the contract in accordance with the terms of the contract.

Please refer to the MCO accreditation status chart in Section C of the waiver for the accreditation status of the three MCOs currently contracted with the State.

c. __X__ **Consumer Self-Report Data**

__X__ CAHPS (please identify which one): *CAHPS Health Plan Survey: Child Medicaid Survey 5.1*
___ State-developed survey
___ Disenrollment survey
__X__ Consumer/beneficiary focus groups – MCO **(You can ignore this X)**

RESPONSE:

CAHPS

- Applicable Programs: MCO
- Personnel responsible: MCO and State staff.
- Detailed description of strategy:

MCO

The state requires the use of the current National Committee of Quality Assurance (NCQA) Consumer Assessment of Health Plans Survey (CAHPS). The survey requirements for the Child CAHPS are documented in state regulation (19 CSR 10-5.010) and may be found at: *http://health.mo.gov/data/managedcare/data.php*.

- Frequency of use: The CAHPS is administered annually by an NCQA-certified vendor.
- How it yields information about the area(s) being monitored: The surveys are used to monitor choice, marketing, information, grievances, timely access, PCP/specialist capacity, coordination/continuity, provider selection, and quality of care. The survey responses are analyzed to create the CAHPS composite (basic information regarding access, availability, and provider competence) and to measure member satisfaction with care. This information is utilized to identify issues for performance improvement projects.

Consumer/Beneficiary Focus Groups – MCO

- Applicable program: MCO
- Personnel responsible: State staff
- Detailed description of strategy: The Member Advisory Committee (MAC) is offered by the MCOs. It is composed of MO HealthNet participants and consumer advocates, works closely with the MO HealthNet Division and the State Quality Assessment & Improvement (QA&I) Advisory Group. The Member Advisory Committee provides valuable insight into the requirements for a quality managed health care system for the state. The Committee makes recommendations to the QA&I Advisory Group for system improvements for quality care.
- The QA&I Advisory Group will make regular reports to the MO HealthNet Member Advisory Committee. The MAC is currently transforming into a more inclusive stakeholder group comprised of both managed care members and Fee-for-Service participants. It is expected to continue to provide vital consumer input.
- Frequency of use: Periodic
- How it yields information about the area(s) being monitored: This consumer feedback is used to obtain additional information for better monitoring activities that address grievance processes, timely access, PCP/Specialist capacity, and quality of care. The MAC provides information regarding the effectiveness of the program. The MAC assists in the identification of strengths and weaknesses. Information is obtained from the members regarding topics that are presented to them. The members ask questions and information is presented in response to those inquiries. The primary focus is to obtain information about problems or opportunities for improvement regarding quality, access, and program impact.

d. __**X**__ Data Analysis (non-claims)

___ Denials of referral requests
__**X**__ Disenrollment requests by enrollee
__**X**__ From MCO
__**X**__ From PCP within MCO
__**X**__ Grievances and appeals data
___ PCP termination rates and reasons
__**X**__ Other (please describe): MCO: DHSS Maternal and Child Health Indicators. ToRCH: CIE platform data, PCP partners' clinical data

RESPONSE:

- Applicable Programs: MCO
- Personnel responsible: MCO and state staff.

- Detailed description of strategy: Data submitted by MCOs and abstracted from state databases is analyzed regarding access, availability, program impact, and quality.
- Frequency of use: Ongoing process. Some processes are performed annually, quarterly, and/or monthly.
- How it yields information about the area(s) being monitored: The MCO data is primarily utilized to monitor marketing, enrollment/disenrollment, program integrity, beneficiary information, timely access, grievances, PCP/specialist capacity, coordination/continuity of care, coverage authorization, provider selection, and quality of care. The data is analyzed to identify trends; to ensure that quality health care services are provided to enrollees; to ensure MCOs are in compliance with federal, state, and contract requirements; and to contribute to a process that partners with MCOs to improve care. The MCO analysis findings are reported to the QA&I Advisory Group. The advisory group members discuss the findings to identify opportunities for improvement.
- Applicable Programs: ToRCH
- Personnel responsible: ToRCH data analysts and state staff.
- Detailed description of strategy: Clinical data submitted by PCP partners and downloaded by the CIE platform are analyzed regarding Program Integrity, Information to Beneficiaries, Timely Access, Coordination/Continuity, Coverage/Authorization, and Quality.
- Frequency of use: Ongoing process. Data are monitored at least monthly, with formal measures reported quarterly.
  How it yields information about the area(s) being monitored: The CIE platform data are primarily utilized to monitor Information to Beneficiaries, Timely Access, Coordination/Continuity, and Coverage/Authorization. Clinical data on key health outcome metrics are analyzed to look for causal effects of the ToRCH model in general and the provision of specific HRSN services in particular. All data are analyzed to identify trends. Each ToRCH Leadership Board discusses the findings to identify opportunities for improvement, and state staff review and identify common trends across the ToRCH sites.

e. __**X**__ Enrollee Hotlines operated by State

RESPONSE:

- Applicable programs: MCO
- Personnel responsible: State staff
- Detailed description of strategy: State participant hotline staff collects information from MCO enrollees and refers the information to the state staff

equipped to resolve the issue. The information obtained from enrollees is integrated into the grievance and appeal analysis process.

- Frequency of use: Data is analyzed quarterly.
- How it yields information about the area(s) being monitored: The MCO information is used to monitor enrollment/disenrollment, program integrity, information to beneficiaries, grievances, timely access, PCP/specialist capacity, coordination/continuity, coverage authorization, provider selection, and quality of care. The information collected is analyzed to identify trends and to ensure that quality services are provided to enrollees.

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. __**X**__ Geographic mapping of provider network

RESPONSE:

- Applicable Programs: MCO
- Personnel responsible: MCO and state staff.
- Detailed description of strategy: Provider Network Adequacy is monitored through standards outlined at the following link in accordance with 42 CFR 438.68: https://mydss.mo.gov/media/pdf/provider-network-adequacy-standards.
- Frequency of use: Provider network adequacy is analyzed on a quarterly basis following standards previously provided. Results are posted on our MHD's website at the following link: https://mydss.mo.gov/mhd/network-access.
- How it yields information about the area(s) being monitored: This process obtains monitoring information for timely access and PCP/specialist capacity. The software program produces a report that is analyzed for compliance with federal regulations and state standards. If deficiencies are noted, an exception must be obtained or MCOs must perform corrective action until in compliance.
- Applicable Programs: ToRCH
- Personnel responsible: ToRCH data analysts and state staff.
- Detailed description of strategy: GeoMapping is embedded in the CIE platform and allows monitoring of Coordination/Continuity and Provider Selection.
- Frequency of use: Ongoing process. Data are monitored at least monthly, with formal measures reported quarterly.
- How it yields information about the area(s) being monitored: Part of coordination of care in a rural community is ensuring geographic access to services, which will be visible in the CIE platform. This will also allow ToRCH analysts and state staff to spot deficiencies, i.e., places where CBOs

are too far away to provide reasonable access to certain services. This will allow corrections to take place.

h. _____ Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

i. _____ Measurement of any disparities by racial or ethnic groups

j. __**X**__ Network adequacy assurance submitted by plan [**Required** for MCO]

RESPONSE:

- Applicable Programs: MCO
- Personnel responsible: MCO and state staff.
- Detailed description of strategy: The network composition is analyzed to identify if the provider network is capable of meeting the needs of the MCO enrollees.
- Frequency of use: Annual and as indicated by monitoring results.
- How it yields information about the area(s) being monitored: The MCO information is used to monitor grievances, PCP/specialist capacity, timely access, and provider selection. The data is used to ensure compliance with contractual requirements and to ensure quality of health care services.

- **In addition, the MCO of the Specialty Plan's Network Development and Management Plan shall include the following:**

- A summary of the Specialty Plan's provider training and education activities, including those promoting the delivery of trauma-informed and evidence-based services;
- A summary of the Specialty Plan's strategies for expanding its network of providers with experience and expertise in treating the needs that are common to children and young adults in the Specialty Plan such as abuse, neglect, sexual offender behavior, comorbid complex conditions, and trauma exposure; and
- An OOS placement summary that includes the number of members placed OOS during the reporting period, a description of the unique needs of the members or circumstances that necessitate placement OOS, and the efforts by the Specialty Plan to develop in-network options.

k. __**X**__ Ombudsman

RESPONSE:

- Applicable Programs: MCO

- Personnel responsible: Legal Services of Eastern Missouri, Legal Aid of Western Missouri, Mid Missouri Legal Services, and Legal Services of Southern Missouri.
  Detailed description of strategy: These four contractors assist MCO enrollees in the Eastern, Central, Western, and Southwestern Regions with accessing their benefits and provide education and outreach. In addition, the four contractors report areas of concern regarding the MO HealthNet Managed Care Program identified through their activities.
- Frequency of use: Ongoing
- How it yields information about the area(s) being monitored: The ombudsmen provide information for the monitoring of choice, marketing, enrollment/disenrollment, program integrity, information to beneficiaries, grievances, timely access, PCP/specialist capacity, coordination/continuity, coverage authorization, provider selection, and quality of care. The contractors provide semi-annual reports and information on an ongoing basis to the state. Their input is integrated into ongoing monitoring of contractual compliance.

l. **X** On-Site Review

RESPONSE:

- Applicable Program: MCO
- Personnel responsible: State and EQRO staff
- Detailed description of strategy: The EQRO (for MCOs only) and/or state staff perform onsite reviews to obtain additional information regarding contractual compliance and quality programs at the MCO sites. The review entails interview of MCO staff and review of MCO processes.
- Frequency of use: Annually by the EQRO (for MCOs). In the instance that a new MCO is contracted, the state will perform a readiness review as indicated.
- How it yields information about the area(s) being monitored: This MCO information is used to monitor information to beneficiaries, grievances, timely access, coordination/continuity, coverage authorization, provider selection, and quality of care. Information from the onsite review is used to ensure compliance with contractual requirements and to ensure quality of health care services.
- Applicable Program: ToRCH
- Personnel responsible: State staff
- Detailed description of strategy: State staff perform onsite reviews to obtain additional information regarding Choice, Marketing, Coordination/Continuity, and Quality at the ToRCH sites. The review entails interview of ToRCH staff and PC and CBO partners and review of the ToRCH site's processes.
- Frequency of use: Annually.
- How it yields information about the area(s) being monitored: Onsite reviews allow state staff to assess whether individuals have adequate choice of PC

providers participating in the ToRCH model in order to access the additional services. It allows an in-depth assessment of the strengths of community partnerships, which are a cornerstone of the model. It allows an assessment of any community-level marketing strategies that the ToRCH entity is employing in the rural community. Finally, it provides an opportunity to assess whether the overall entity, including the Leadership Board, is functioning well as a community.

m. **X** Performance Improvement Projects [**Required** for MCO]

X Clinical
X Non-clinical

RESPONSE:

- Applicable Program: MCO
- Personnel responsible: MCO, EQRO, and state staff
- Detailed description of strategy: The MCOs develop and implement performance improvement projects (PIPs) as a result of activities through their quality programs and report results to the state annually. The EQRO validates two PIPs per year, in accordance with EQR protocols. The state agency will require a total of two PIPs of the MCOs contracted for the General and Specialty Plan. The state incorporates information obtained from the MCOs and EQRO in its annual evaluation of the MO HealthNet Managed Care Program.
- Frequency of use: Ongoing
- How it yields information about the area(s) being monitored: The PIPs are used to monitor grievances, information to beneficiaries, coordination/continuity, and quality of care. Information from the PIPs is used to ensure compliance with contractual requirements and to ensure delivery of quality health care services.

n. **X** Performance measures [**Required** for MCO]
Process
Health status/outcomes
Access/availability of care
Use of services/utilization
MCO stability/financial/cost of care
MCO/provider characteristics
Beneficiary characteristics

RESPONSE:

- Applicable Program: MCO
- Personnel responsible: MCO and state staff.

- Detailed description of strategy: MCOs produce contractually required HEDIS measures following HEDIS specifications. State staff produce secondary source performance measures using information reported to the Department of Health and Senior Services.
- Frequency of use: Annually.
- How it yields information about the area(s) being monitored: Performance measures are used to monitor grievances, timely access, coordination/continuity, and quality of care. The performance measures are used to ensure delivery of quality health care services.

RESPONSE:

- Applicable Program: ToRCH
- Personnel responsible: ToRCH and state staff.
- Detailed description of strategy: State staff will utilize a closed-loop community information exchange (CIE) referral platform to measure performance and produce dashboards and analytics to visualize success on defined goals. Performance measures are used to monitor Program Integrity, Timely Access, and Quality of Care. The performance measures are used to ensure delivery of quality health care services.
- Frequency of use: Quarterly.
- How it yields information about the area(s) being monitored: The integrity of the ToRCH program depends upon all Medicaid populations being screened, referrals being closed by all community partners at high rates and in a timely manner, and by services being deployed efficiently in order to close gaps. These will be the process measures until data on performance measured by claims – hospitalization utilization – are available.

o. _____ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ____ Profile utilization by provider caseload (looking for outliers)

q. ____ Provider Self-report data
___ Survey of providers
___ Focus groups

r. **X** Test 24 hours/7 days a week PCP availability

RESPONSE:

- Applicable Program: MCO
- Personnel responsible: MCO and state staff
- Detailed description of strategy: MCOs are required to assess the availability of PCPs for 24 hours and 7 days per week availability. The MCO provider representatives and the Quality staff generally perform this task. The tasks include monitoring grievances, provider office site visits, secret shopper calls, interviews with staff, and provider education, if indicated. The MCOs report monitoring results to the state staff. State staff evaluate the reports to ensure enrollees have 24/7 access to PCP services.
- Frequency of use: Annually.
- How it yields information about the area(s) being monitored: This information is used to monitor grievances, timely access, PCP/specialist capacity, and provider selection. This information is used to ensure compliance with contractual requirements and to ensure delivery of quality health care services.

s. **X** Utilization review (e.g. ER, non-authorized specialist requests)

RESPONSE:

- Applicable Program: MCO
- Personnel responsible: MCO and state staff
- Detailed description of strategy: This process includes ongoing monitoring of MCO utilization management data and MCO encounter data review.
- Frequency of use: Quarterly.
- How it yields information about the area(s) being monitored: MCO utilization reviews are used to monitor program integrity, grievances, timely access, PCP/specialist capacity, coordination/continuity, coverage authorization, provider selection, and quality of care. The utilization reviews are used to ensure delivery of quality health care services.
- Applicable Program: ToRCH
- Personnel responsible: ToRCH leadership boards and state clinical staff
- Detailed description of strategy: ToRCH sites will be assessed on avoidable ED use, avoidable hospitalizations, and all-cause hospital utilization among Medicaid participants in each ToRCH community, relative to each other and relative to Medicaid participants in non-ToRCH rural counties, adjusted for demographics. ToRCH utilization reviews are deployed to examine outliers in order to monitor program integrity and quality of care, ensuring that no patients are inappropriately diverted from a necessary hospitalization.
- Frequency of use: Quarterly.
- How it yields information about the area(s) being monitored: The utilization reviews are used to ensure delivery of quality health care services and that no

sites are achieving targets by means of inappropriate restriction of hospital services.

t. __**X**__ Other: (please describe)

RESPONSE:

The ToRCH model has an oversight structure that includes a State Advisory Committee as well as Community Leadership Boards at each site. Medicaid participants and/or consumer advocates are members of each Community Leadership Board. These groups meet monthly and will address all monitoring matters, grievances, etc., on that cadence. ToRCH communities' performance in terms of engaging community partners who can meet the ToRCH goals of closing the loop on referrals originating with clinical partners, i.e., ensuring participants' HRSN needs are being met in a timely fashion, will be closely monitored. Performance of the ToRCH site as a whole will be monitored by state staff using data produced by the CIE platform vendor. Assessment of equitable access across the geography of the ToRCH service area will be conducted as well.

- Applicable Program: ToRCH
- Personnel responsible: ToRCH leadership boards and state staff
- Detailed description of strategy: ToRCH sites will be assessed on several quality metrics related to referral activity, which the sites will analyze at the level of each CBO partner. State staff will monitor these metrics to ensure that the Leadership Boards are responding to low-performing partners appropriately. These strategies help monitor Enrollment/Disenrollment, Program Integrity, Grievances, and Quality of Care.
- Frequency of use: Quarterly.
- How it yields information about the area(s) being monitored: One of the activities in the Community-PCCM approach is to provide leadership, monitoring, and engagement of CBO partners. Tracking the ongoing participation of those CBO partners and the corresponding responses of the ToRCH entity demonstrates that the ToRCH entity is using a strategic, data-driven approach to success. Furthermore, assessing the volume of referrals and analyzing them along various dimensions will ensure that ToRCH dollars are invested in places where they will achieve the greatest health improvements in a manner that is equitable and sustainable.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

__X__ This is a renewal request.

- ___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- __X__ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy: Accreditation for Participation.

RESPONSE:

MCO

Sources: National Committee on Quality Assurance or URAC

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

MO HealthNet Health Plan NCQA Accreditation

	Expiration Date	Level of Accreditation	Patient Experience (out of 5.0)	Prevention and Equity (out of 5.0)	Treatment (out of 5.0)	Rating (out of 5.0)
United Healthcare	08/17/2027	Accredited	3.5	2.0	2.5	3.0
Healthy Blue, Inc. dba Healthy Blue	09/20/2026	Accredited	3.0	2.0	2.5	3.0
Home State Health	04/28/2026	Accredited	4	2.0	2.5	3.0

NCQA Accreditation as of June 30, 2023	
I = Insufficient Data	
NC = No Credit	
NA = Not Applicable	

Lower Performance						Higher Performance		
≤1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0

To help ensure that quality and performance are maintained between surveys, the organization must submit audited HEDIS results annually for the HEDIS measures in accreditation at the time of the organization's last Full Accreditation Survey. NCQA uses the annual results to reevaluate the organization's performance on specified HEDIS/CAHPS measures, and may change the organization's accreditation status based on the results.

Summary of Results:
Problems Identified: Not applicable.
Corrective Action (MCO/provider level): Not applicable.
Program change (system-wide level): Not applicable.

Strategy: Consumer Self-Report Data CAHPS-H/ State developed survey/Managed Care Member Focus Group.

RESPONSE:

MCO

Sources: 2021 Consumer Assessment of Health Plans Survey (CAHPS), MO HealthNet Division

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: The MO HealthNet Managed Care contract requires the MCOs to submit member satisfaction data to the Department of Health and Senior Services (DHSS) annually. The MCOs conduct the Consumer Assessment of Health Plans Survey (CAHPS) to meet this requirement.

Data from annual CAHPS Surveys is located on the Quality Dashboard at the following link: https://mydss.mo.gov/mhd/quality-dashboard.

In the comparison between MO HealthNet Managed Care Plans and National Medicaid, the MO HealthNet Managed Care plans exceed the National Median for multiple measure categories.

Problems identified: Review of CAHPS results does not identify problems with the MO HealthNet Managed Care Program.

Corrective action (MCO/provider level): Not applicable.

Program change (system-wide level): Not applicable.

Managed Care Member Focus Group

MCO

Sources: MO HealthNet Community Connection (MCC) meetings. Formerly referred to as the Consumer Advisory Committee (CAC) and MO HealthNet Member Forum.

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

A restructured workgroup called CAC was formed in 2016 to address issues and concerns. One of the outcomes of the workgroup was to establish local CACs throughout the state led by the local consumer members. Leading up to and shortly after the implementation of statewide Managed Care, the CAC held meetings in conjunction with the Taneyville School PTO with CAC members participating in person and via webinar. The state presented information regarding the upcoming open enrollment and used this opportunity to answer questions from the parents who were new enrollees into Managed Care. The CAC also collaborated and participated in a School Nurses Association meeting in Joplin which is a Managed Care extension area. An evening meeting was also held to meet Managed Care consumers at a time and place more conducive to their schedules and to encourage Managed Care consumers in Joplin to establish a local CAC. At the CAC meeting, presentations were made from MHD Staff, Health Plan Staff, Advocates for Family Health/Legal Aid, Missouri Educational Services for Young Children provided by the First Steps Program and the role of School Nurses and MO HealthNet Services. The CAC also outreached to Local Public Health Agencies in the former Fee-for-Service areas to answer questions and provide information.

In 2021, the CAC became the MO HealthNet Member Forum. This group held meetings in various locations of the state to encourage and increase consumer participation, and to provide advice to the MO HealthNet program. Face to face meetings as well as phone, webinar and email communication were utilized to accomplish the work of the Member Forum.

Due to the COVID-19 Public Health Emergency (PHE) these meetings were paused. Once the PHE ended, the meetings consisted of internal meetings along with meetings including health plan staff members. To better reflect the inclusion of participants the group was renamed MO HealthNet Community Connection (MCC). Members of this group attended events conducted by the health plans. In addition, information about this group was included on the MO HealthNet website. Due to upcoming changes from the Centers for Medicare & Medicaid Services (CMS), the meetings of the MCC were paused in August 2024.

Due to CMS Final Rule 89-40542, the MCC transitioned to become MO HealthNet's Beneficiary Advisory Committee in July 2025. The first MCC meeting under the new structure was held on August 28, 2025.

Problems identified: There were no problems identified at that time.

Corrective action (MCO/provider level): Not applicable.

Program change (system-wide level):
The CAC was replaced by the Member Forum, and transformed into a more inclusive stakeholder group that included managed care and Fee-for-Service participants.

The group name changed to MO HealthNet Community Connection (MCC) in February 2024. The purpose of the group remained the same, but the new name reflected a more holistic approach.

Due to CMS Final Rule 89-40542, MO HealthNet transitioned the MCC to meet the requirements of a Beneficiary Advisory Council in July 2025. The MCC brings together MO HealthNet participants, caregivers, and family members with lived experience with the MO HealthNet Program to share feedback, spark change, and help shape the future of the program.

Strategy: Data Analysis

RESPONSE:

MCO

Sources: Missouri Department of Social Services, MO HealthNet Managed Care, Managed Care Health Plans annual reports, aggregate quarterly grievances data, MO HealthNet Encounter Data, DHSS Maternal and Child Health Indicators.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: The state continues to work with the MCOs to ensure submission of encounter data, member and provider complaints, grievances, and appeals; detection of fraud and abuse; tracking enrollment; generating administrative data for decision making; reporting lead case management activities in the DHSS database; and assessing MCO contract compliance. The state has assisted the MCOs in meeting compliance review standards for Enrollee Rights by reviewing and standardizing MO HealthNet Managed Care Member Handbooks; developing consistency in grievance systems; fraud and abuse systems, and lead case management; and reviewing the Information System Capabilities Assessment (ISCA) reports. The state has provided for ongoing communication with the MCOs through scheduled face-to-face and conference call meetings.

Member and Provider Complaints, Grievances, and Appeals

MCOs are required to submit monthly member and quarterly provider complaint, grievance, and appeal reports per the MO HealthNet Managed Care contract. The MO HealthNet Division (MHD) analyzes the reports for quality and effectiveness of care and access. The data is compiled into uniform region and statewide reports.

Member grievances and appeals for State Fiscal Year 2022 (SFY2022), which covers the period of July 1, 2021, to June 30, 2022, were examined using the following categories:

- Health Plan/Provider Policy
- Provider Staff Behavior
- Health Plan Staff Behavior
- Appointment Availability
- Network Adequacy/Availability
- Waiting Times (office/transportation)
- Condition of Office/Transportation
- Treatment Plan/Diagnosis
- Provider Competency
- Interpreter Services
- Fraud and Abuse of Services
- Member Receiving Bills/Provider Requesting Payment Before Rendering Services
- Health Plan Information
- Provider Communication
- Member Rights
- Service Denial
- Service Reduction, Suspension or Termination
- Payment Denial
- Timeliness of Service
- Prior Authorization Timeliness
- Other

During SFY 2022, MCOs had the following number of member grievances and appeals:

- United Healthcare reported 197 grievances and 231 appeals.
- Home State reported 199 grievances and 360 appeals.
- Healthy Blue reported 389 grievances and 181 appeals.

The most frequent grievances were receiving bills/provider requests payment for rendering services, service denial, service reduction, suspension or termination, and staff behavior.

The most frequent appeal in all regions served by the three MCOs was service denial followed by payment denial.

Provider Complaints and Appeals

Provider complaints and appeals for SFY 2022, were examined using the following categories:

- Claim Denial
- MCO Policy
- MCO Information Systems
- Network Adequacy/Availability
- MCO Staff Behavior

- Interpreter Services
- Member Behavior
- Member Compliance with Treatment Plans
- Member Missed/Late Appointments
- Member Communication
- Referral Process
- Service Denial
- MCO PA Process
- Timeliness of Payment
- Fraud and Abuse of Services
- Transportation
- Other

During SFY 2022, MCOs had the following number of provider complaints and appeals:

- United Healthcare reported 4,242 provider complaints and appeals.
- Home State reported 1,646 provider complaints and appeals.
- Healthy Blue reported 4,535 provider complaints and appeals.

The most frequent statewide provider complaints or appeals were for claim denial, followed by service denial.

Service Utilization

According to the Health Effectiveness Data Information Set (HEDIS) Annual Dental Visits Combined Rate indicator, the statewide average of all MCOs increased from 42.32% in HEDIS 2021 (data year 2020) to 42.44% in HEDIS 2023 (data year 2022).

Maternal and Child Health Indicators

Objective

The Trends in Missouri MO HealthNet Quality Birth Indicators Report is used to examine the impact of the MO HealthNet Managed Care Program on maternal/infant and child health since the inception of the MO HealthNet Managed Care Program and to compare this progress with Non-Medicaid and MO HealthNet Fee-for-Service participant groups. The birth data comes from the birth certificate using source of payment to determine Medicaid status and county of residence to determine Managed Care or Fee-for-Service.

The Managed Care Organizations (MCO) Specific Birth Report: 2022 Missouri Resident Live Births report provides patient abstract data by specific MCO. It also provides state totals for 2022.

- The adequate prenatal care rate increased by 1.7% between 2020 and 2022 among the MO HealthNet Managed Care population, from 70.9% to 72.6%. The rate went up in all regions

for the established three (3) health plans (Home State Health, Healthy Blue and United Healthcare).

- C-Sections in Managed Care regions increased by 0.5% from 2020 to 2022 within the MO HealthNet Managed Care population, from 29.3 to 29.8%. The Southwest region had the lowest C-Section rate of 28.8%. The Fee-for-Service C-Section rate was higher in 2022, at 31.3 %.
- VBAC rates in Managed Care Regions increased slightly by .2% from 2020 to 2022, rates went from 16.7% to 16.9%. The Southwestern and Eastern regions reported increased rates of VBAC.
- Overall rates of smoking during pregnancy for MHD enrollees declined in the past two years, from 23.8% to 14.5% for Fee-for-Service, and from 21.0% to 14.6% for Managed Care. Decreases were seen in all Managed Care regions. The Central Region continues to have significantly higher rates than the other three regions.
- Short birth spacing decreased only in the Eastern region, among Managed Care participants, while increasing in the other three regions.
- Teen births to mothers less than age 18 increased slightly in the Managed Care Central Region and decreased in the other three regions between 2020 and 2022.
- Repeat teen births decreased in Managed Care and Fee-for-Service from 2020 to 2022.
- Women Infant and Children (WIC) participation rates have decreased from 59.4% in 2020 to 52.2% in 2022. The 2022 WIC participation rate among Managed Care births was much higher than the Fee-for-Service rate (52.2% vs. 41.3%).

Compared with rates for all Missouri births and to births in the Fee-for-Service population, Managed Care MO HealthNet births generally had lower rates of C-Sections and low birth weights, and higher rates of adequate and early prenatal care.

Problems identified: Regarding the grievance, complaints and appeals data, the rate per 1,000 members is low indicating that members are not having major issues accessing their benefits under MO HealthNet Managed Care. In regard to births, pregnancies and prenatal care, Managed Care experienced some shortfalls in these areas that need to be addressed in the future.

Corrective action: All three health plans have operated member incentives to improve prenatal care: Home State Health, Healthy Blue, and United Healthcare all operate a gift card member incentive program to increase pregnancy, prenatal and postpartum visits.

Program change (system-wide level): Beginning July 1, 2019, the managed care contract was revised to include a new Performance Withhold Program designed around HEDIS measures and aligned with the state's Quality Improvement Strategy. Included in this program are the Timeliness of Prenatal Care (prenatal visit occurred in the first trimester or within 42 days of new enrollment) and Postpartum Care (deliveries that had a postpartum visit on or between 21 and 56 days after delivery) HEDIS measures. Health plans must demonstrate a rate increase from the prior year of at least two percentage points or meet the 50th percentile on the NCQA Quality Compass to receive the performance withhold on each measure. Prenatal and Postpartum care HEDIS rates have remained in the Performance Withhold program since 2019. In general, these rates have improved;

however, the PHE had a negative impact on HEDIS measures on a national level. Targets for the performance withhold program were adjusted temporarily and are trending back towards pre-COVID goals.

Strategy: ***Enrollee Hotlines***

RESPONSE:

MCO

Source: MO HealthNet Managed Care Contract Compliance Unit logs.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: The MO HealthNet Division's (MHD) Participant Services Unit has the responsibility for calls, email and all written correspondence from MO HealthNet participants regarding all aspects of the MO HealthNet Program. The Participant Services Unit takes the initial call, e-mail or written correspondence and forwards information pertaining to Managed Care to the MO HealthNet Education and Training Unit. The Education and Training Unit maintains this same information for providers and refers MO HealthNet Managed Care issues to the respective MCO. During SFY 2022, 2528 issues were received.

Examples of issues reported by members to the Participant Services Unit, which were forwarded to the Education and Training Unit to be resolved, pertained to:

- Appointment Availability
- Claim Denial/Payment/ Timeliness
- MCO Information Systems: Claims, Eligibility, TPL
- MCO Policy Information
- Member Receiving Bills/Provider Requesting Payment Before Rendering Services
- Member Rights
- Network Adequacy/Availability
- Other
- Provider Competency
- Provider Staff Behavior
- Service Denial
- Transportation
- Waiting Times

Examples of issues reported to the Education and Training Unit by providers pertained to:

- Claim Denial
- Fraud and Abuse of Services
- MCO Information Systems: Claims, Eligibility, TPL, MCO Information
- MCO PA Process
- MCO Provider Policy
- Member Behavior
- Member Billed/provider quests pay prior to service
- Network Adequacy/Availability
- Other Prior Authorization Timeliness
- Service Denial
- Transportation

The Education and Training Unit works with the MCOs to resolve all issues.

Problems identified: The majority of the members and providers contacting MHD hotlines did not access the MCOs' member/provider complaint, grievance, and appeal process to resolve their concerns. Once the MCO became involved, their concerns were addressed.

Corrective action (MCO/provider level): MHD staff educated members and providers who contacted the hotlines regarding the availability of the MCOs' complaint, grievance, and appeal processes to resolve any future issues.

Program change (system-wide level): Not applicable.

Strategy: ***Geographic Mapping***

RESPONSE:

MCO

Source: Provider Network Adequacy Standards.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: The state quarterly evaluates network access submitted by the MCOs. The state calculates the enrollee access rate for each type of provider in each county that the MCO serves to determine if the average enrollee access rate for each county and the average enrollee access rate for all counties is greater than or equal to one hundred percent (100%). The entire MO

HealthNet Managed Care population is used in the calculation for each MCO. The 2025 Network Analysis completed by the state are available at the following link: https://mydss.mo.gov/mhd/network-access.

Problems identified: No problems were identified. The network analysis indicates that the MCOs provide adequate network access to all enrollees.

Corrective action (MCO/provider level): Not applicable.

Program change (system-wide level): Not applicable.

Strategy: Network Adequacy Assurance by MCO

RESPONSE:

MCO

Sources: PCPs: Provider data submitted by the MCOs to MHD. (Provider networks as of January 1, 2025).

Enrollees: January 1, 2025, enrollment data from MHD's Cognos reporting system.

Dentists: Provider data submitted by the MCOs to MHD. (Provider networks as of January 1, 2025)

Behavioral Health: Provider data submitted by the MCOs to MHD. (Provider networks as of January 1, 2025).

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: The state determined time and distance to all provider types listed in the Provider Network Adequacy standards located here: https://mydss.mo.gov/media/pdf/provider-network-adequacy-standards.

The results of the analysis are shown on MHD's public dashboard at following link: https://mydss.mo.gov/mhd/network-access. . on MHD's public dashboard at following link: https://mydss.mo.gov/mhd/network-access

Conclusion: Analysis regarding PCP, behavioral health, and dental providers indicate that MCOs are providing adequate access to members. The state modified our Provider Network Adequacy process to align with federal requirements per 42 CFR 438.68, 438.206 effective January 1, 2024. The state will continue to evaluate and analyze all required areas.

Problems identified: No problems were identified.

Corrective action (MCO/provider level): Not applicable.

Program change (system-wide level): Not applicable.

Strategy: Ombudsmen

MCO

Sources: Eastern, Central, Western and Southwestern Ombudsmen 2023 reports.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: Ombudsmen services are available in the Eastern, Central, and Western and Southwestern MO HealthNet Managed Care regions of the state.

Legal Services of Eastern Missouri covers counties in the Eastern and Central Regions. Mid-Missouri Legal Services covers counties in the Central Region. Legal Aid of Western Missouri covers counties in the Western, Central and Southwestern Regions. Legal Services of Southern Missouri covers counties in the Southwestern, Central and Western Regions.

During this waiver period, the ombudsmen submitted semi-annual reports. Below is an analysis of the Eastern, Central, Western, and Southwestern Region ombudsmen reports for 2023 (January-June 2023 and July-December 2023).

Cases Handled by Legal Services of Eastern MO in 2023

January – June 2023
The most frequent problems encountered during this period pertained to Eligibility (89 cases), Dental (47 cases), Availability and Access to Providers (34 cases), General Questions (23), and Specialty Care (18).

The number of cases resolved centered on the Family Support Division (51) and Health Plan Contacts (45).

Concerns for the region:

- Orthodontia denials for children
- Provider Access

- Availability of providers
- Lack of specialists. Mental health providers and dental providers

July- December 2023

The most frequent problems encountered during this period pertained to Eligibility (59 cases), Health Plan Service Denial (44), Availability and Access to Providers (43 cases), Dental (38), and General Questions (23).

The number of cases resolved centered on Other (82), the Family Support Division (48) and Health Plan Contacts (45).

Concerns for the region:

- Orthodontia denials for children
- Provider Access
- Availability of providers in the health plan networks who are accepting new patients.
- Lack of specialists. Mental health providers and dental providers

Cases Handled by Mid-Missouri Legal Services of Central Missouri in 2023

January – June 2023

The most frequent problems encountered during this period pertained to Eligibility (6), General Questions (3), and Recipient Liability (1)

The number of cases resolved centered on Advocates for Family Health (8), FSD (1), and Other (1).

Concerns for the region:

- Delays in the processing of applications
- Adding individuals to member households
- Members switching from one category of MO HealthNet benefits to another
- Concerns related to Pharmacies providing prescriptions to MO HealthNet participants

July – December 2023

The most frequent problems encountered during this period pertained to Eligibility (6), General Questions (3), Recipient Liability (1), Dental (1), and Enrollment (1).

The number of cases resolved centered on Advocates for Family Health (8), FSD (2), and State Fair Hearing (1).

Concerns for the region:

- Issues with the document upload system
- CHIP premium payment concerns
- Delays in application processing
- Concerns with the FSD call center

Cases Handled by Legal Services of Western Missouri in 2023

January – June 2023

The most frequent problems encountered during this period pertained to Application Problems (20), Enrollment Problems (13), and Recipient Liability Problem (3)

The number of cases resolved centered on AFH Project Staff (36), Provider (21), and Family Support Division (11)

Concerns for the region:

- Language Access Issues
- Generally Improving FSD Forms and Notices
- Call Center Access Issues
- Managed Care Plans Orthodontia Dental Notices

July – December 2023

The most frequent problems encountered during this period pertained to Enrollment Problems (64), Application Problems (9), and Recipient Liability Problem (8).

The number of cases resolved centered on AFH Project Staff (79), Provider (49), and Family Support Division (8)

Concerns for the region:

- Language Access Issues
- Generally Improving FSD Forms and Notices
- Call Center Access Issues
- Managed Care Plans Orthodontia Dental Notices

Cases Handled by Legal Services of Southern Missouri in 2023

January - June 2023

The most frequent problems encountered during this period pertained to Eligibility (1) and Enrollment (1)

The number of cases resolved dealt with Other (2), which involved providing general information or assistance to the applicant.

Concerns for the region:

- Advocates of the clients who utilize MO HealthNet need continued training and general information concerning MO HealthNet rules and regulations.
- The local community service organizations need continued education concerning client referrals to the appropriate health care providers.
- The local community service organizations and governmental entities need continued education concerning client referrals to the Advocates for Family Health program.

July- December 2023

The most frequent problems encountered during this period pertained to Eligibility (3), Enrollment (3), Dental (2), and Specialty Care (2).

The number of cases resolved centered on Other (6), Resolved Informally (4), and Division of Family Services (1)

Concerns for the region:

- Advocates of the clients who utilize MO HealthNet need continued training and general information concerning MO HealthNet rules and regulations.
- The local community service organizations need continued education concerning client referrals to the appropriate health care providers.
- The local community service organizations and governmental entities need continued education concerning client referrals to the Advocates for Family Health program.

Problems identified: Access to providers and enrollment, FSD call center, and Dental/Orthodontia.

Corrective action (MCO/provider level): Ombudsmen in the Eastern, Central, Western and Southwestern Regions participated in outreach and educational activities in their respective regions. These activities included, but were not limited to:

- Educational programs were presented to social workers and case managers from various providers.

- Educational programs were presented to FSD eligibility specialists and supervisors in various counties.
- Participation in virtual health fairs distributing informational flyers regarding MO HealthNet, managed care and services provided by the ombudsmen.
- Participation in the MO HealthNet Community Connection (MCC).
- Participation in various community task forces and health groups.
- Distribution of outreach and educational flyers to various health care providers throughout the three regions.

Program change (system-wide level): Not applicable.

Strategy: On-Site Reviews

RESPONSE:

MCO

Source: EQRO Report for calendar year 2021.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

EQRO Report for calendar year 2021

The 2022 EQR report summarized the findings of the mandatory activities for External Quality Review of the MCOs. The EQR report analyzed and aggregated calendar year 2021 data from three mandatory EQR activities (Validating Performance Improvement Projects (PIPs), Validating Performance Measures (PM), and MCO Compliance with Managed Care Regulations). In these reports, MCOs are referred to as Managed Care Health Plans or MCOs.

Validation of Performance Improvement Projects

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with health care outcomes. The MO HealthNet Division requires the contracted MCO to conduct PIPs that are designed to achieve, through ongoing measurements and interventions, a significant improvement, sustained over time, in clinical care and non-clinical care areas. The PIPs are expected to have a favorable effect on health outcomes, member satisfaction, and improved efficiencies related to health care service delivery. They are to be carried out over multiple re-measurement periods and under the MCO's contracts

with the State of Missouri, each MCO is required to have two active PIPs; one of them is clinical in nature, and the other one non-clinical.

The selected PIPs are Improving Oral Health (HEDIS measure ADV: Annual Dental Visits) as the non-clinical PIP, and Improving Childhood Immunization Status (HEDIS measure CIS: Childhood Immunization Status Combo 10) as the clinical PIP.

Quality of Care

The topics identified by all MCOs for their PIPs provide evidence of their commitment to providing quality services to members. The PIPs focus on improving direct services to members. Some PIP interventions were designed to address barriers to quality care. These included partnering with Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs). These initiatives targeted members who were not utilizing their childhood immunization or annual dental visit benefits.

All the PIPs reviewed included the stated goal of providing quality health care services. However, some PIPS did not identify how effective current interventions were in 2022 (based on 2021 data) review. This is an area Missouri continues to address and refine for future PIPs. The current PIPs include the improvement of specific HEDIS measures. The results of PIP interventions conducted are difficult to tie back to the increase or decrease of the HEDIS measures. The MCOs must focus on new and creative initiatives that can be clearly linked to the HEDIS measures to help them meet this goal.

Access to Care

The MCOs developed projects that targeted members' ability to obtain dental care and childhood immunizations by expanding service availability. These projects have the potential to create improved preventive and primary care for members. Although the clinical PIPs have seen meager improvement each year, the non-clinical PIPs, submitted by all three MCOs, saw some significant improvements to the ADV HEDIS measure in CY 2018. However, in CY 2020, all three MCOs saw a decline to the ADV HEDIS measure due to the COVID-19 Pandemic. PIP interventions conducted in CY 2022 (based on 2021 data) indicate some improvement to the ADV HEDIS measure; however, during the EQRO's evaluation, the HEDIS measures were assigned a score of "No Confidence" in terms of execution and the probability of being linked to improvement.

Timeliness of Care

Timeliness of care was also addressed in the PIPs reviewed. Projects addressed timely access to dental care and childhood immunizations and concentrated on the need for timely and appropriate care for members. The Improved Oral Health PIPs included interventions to improve timeliness of care. These interventions and discussions with MCO staff reflect an awareness of the importance of timely health care.

Conclusions

Based on the PIP validation process, all the MCOs had active and ongoing PIPs as part of their quality improvement programs. A need to revitalize a commitment to the quality improvement process was observed when evaluating the outcomes of the PIPs. Based on the EQRO's analysis, although there were slight improvements made for the clinical PIP, Improving Childhood Immunization Status, the PIPs were scored as "No Confidence" for all MCOs. These no confidence scores relate back to the inability to link the HEDIS measure's outcome to the PIP interventions in a clear manner. The PIPs exhibited sound planning, but the analysis and reporting need improvement. The PIPs did not provide enough information to relate the interventions to the outcomes reported. Additional work is needed to create measurements for each intervention to assess whether that intervention is successful.

All the PIPs submitted that contained reportable outcomes included some narrative in the data analysis. How the interventions contributed to success, or analysis of why interventions did not create the desired changes, was not included. This type of evaluation is as important as the data analysis presented.

The interventions developed for the PIPS remain inadequate. The MCOs continue to use and reuse interventions that have failed to create the change hoped for in these projects. Innovative approaches to positively impact the problems identified are necessary. As interventions are implemented, a method to measure each intervention's outcome must also be introduced.

Recommendations

- MCOs must continue to refine their skills in the development and implementation of approaches to affect change in their Performance Improvement Projects. Establishing a clear baseline and measurement along with conducting the PIP over a reasonable time frame are necessary to gauge improvement. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.
- Data collection plans should be consistent with the data analysis plans and Plan-Do-Study-Act (PDSA) cycles should be utilized to test the intervention.
- Improvement should be linked to the quality improvement processes implemented.
- Interventions should tie to an improvement by correct analysis and interpretation.

Validation of Performance Measures

The Validation of Performance Measures Reported by the MCO Protocol requires the validation or calculation of three performance measures at each MCO by the EQRO. The measures selected for validation by MO HealthNet are required to be submitted by each MCO on an annual basis. Any HEDIS measures were also submitted to the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS). For the EQRO 2022 evaluation period, the three performance measures selected for validation were three HEDIS 2021 measures: Well-Child

Visits in the First 30 Months of Life (W30), Chlamydia Screening in Women (CHL), and Follow-Up After Hospitalization for Mental Illness-30 days post-discharge (FUH-30 days).

The EQRO examined the information systems, data integration, data control, detailed algorithms, MCO extract files, medical records, documentation of performance measure rate calculations, and data submissions provided to the MO HealthNet Division and SPHA to conduct the validation activities of this protocol.

A review of the Information Systems Capabilities Assessment (ISCA) was conducted in 2022. Data collection, review, and analysis were conducted for each criterion via the ISCA data collection tools, interview responses, security walk-throughs, and claim/encounter data lifecycle demonstrations. No concerns were identified during the ISCA review.

Quality of Care

The W30, CHL and FUH HEDIS measures were selected for EQRO review due to them being included in the Managed Care Performance Withhold Program. The information gathered in the EQR stresses the importance of the MCOs to have quality care in these areas. This information is useful for the MCOs to determine if their interventions are being utilized properly by its members. The MCOs can also use this information to ensure that the quality of care necessary for members is available.

The EQRO did not identify any specific issues with the quality of care in the performance measures evaluated. The EQRO made suggestions to have the MCOs increase outreach efforts and continue to coordinate with primary care providers.

Access to Care

The EQRO reported there was appropriate access to services such as laboratory, primary care, and hospital access in all regions within the network. Hospital admissions do require proper authorization; however, all participating hospitals are informed of the process for obtaining those authorizations.

The EQRO recommended all health plans continue to follow up once a member is discharged from a hospital following an admission for mental health reasons.

Timeliness of Care

The Well-Child Visit (W30) HEDIS measure specifically looks at the timeliness of care for this vulnerable population. Each health plan submitted final rates for the W30 measure based on services provided in 2021.

Missouri will continue to monitor these measures through the Performance Withhold and foresee improvements due to there being financial incentives tied to them.

Conclusions

All of the MCOs have adequate information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the measures validated.

As mentioned before, Missouri has implemented a new Performance Withhold Program designed to specifically improve HEDIS rates to drive quality, access and timeliness of care.

Missouri has also formed a collaborative group with the health plans to focus on improving the Follow-Up After Hospitalization (30-Day) HEDIS measure. This, in turn, will help continue to reduce readmission rates for mental health.

Recommendations

- The health plans continue to engage members and providers through education and outreach programs.
- The MCOs should continue to incentivize providers to meet with members for the W30 measure.
- Members should be encouraged to seek outpatient mental health services and follow-up once a member is discharged from the hospital following an admission for mental health reasons.
- MO HealthNet is advised to consider including more state custom measures, CMS core set measures, apart from HEDIS measures, for validation purposes.
- MO HealthNet is advised to work with the MCOs to track, monitor, and measure interventions taken to improve performance of the W30, CHL, and FUH measures.

Compliance with Medicaid Managed Care Regulations

The purpose of the protocol to monitor MCO Compliance with Managed Care Regulations is to provide an independent review of MCO activities and assess the outcomes of timeliness and access to the services provided. The policy and practice in the operation of each MCO were evaluated against the regulations related to operating a Medicaid managed care program. The standards from 42 CFR 438 Subpart D that were reviewed in EQR 2022 were: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, and Grievance and Appeal System.

Quality of Care

Coordination and Continuity of Care for each health plan scored as "Met" during the 2022 EQR. The health plans all have policies and procedures that address the transition of care requirements in the managed care contract.

Access to Care

Availability of Services for each health plan scored as “Met” during the 2022 EQR. Travel standards set by the Missouri Department of Commerce and Insurance are followed to ensure enrolled members continue to have adequate access to care. Health plans maintain and monitor a network of appropriate providers, which is supported with written agreements to cover all services under the contract, including those with limited English proficiency or physical/mental disabilities.

Healthy Blue and Home State Health obtained the highest rating for coverage and authorization of services at 95%. Healthy Blue obtained a 89% and United Healthcare received 76%. The EQRO identified some “Partially Met” items in United Healthcare’s review in relation to policy clarifications needing to be made for family planning services and the payment of custom items.

Missouri health plans provide for the transfer of relevant member information, including medical records and other pertinent materials, to another MCO upon notification of establishment of care such that the transition of care is seamless.

Timeliness of Care

The 2022 EQR review confirms coverage and authorization services offered by each MCO comply with the services identified in the MHD contract. Emergency medical and behavior health or substance abuse services are available 24 hours a day and 7 days a week to treat an emergency medical condition. Prior authorization is not required for these services.

Home State Health collects after-hours accessibility data on PCPs that cover 50% of their members to improve their timeliness of care. They also monitor high volume specialists to ensure members have access to medical care 24/7.

Home State Health and Healthy Blue conduct internal telephone surveys of their contracted providers to ensure appointment compliance.

Health plans also utilize the Consumer Assessment of Healthcare Providers and System (CAHPS) member survey feedback on experience with Getting Needed Care and Getting Care Quickly.

Conclusions

Overall results for the 2022 EQR reflect a confidence level of 91% for Home State Health with six of the compliance criteria "Partially Met" and one "Not Met", Healthy Blue received a confidence level of 77% with five of the compliance criteria "Partially Met" and two "Not Met", and United Healthcare received a confidence level of 88% with six of the compliance criteria "Partially Met" and three "Not Met".

All sources of available documentation, interviews, and observations at the on-site review were used to develop the ratings for compliance. The EQRO comments were developed based on review of this documentation and interview responses. The following summarizes the strengths in the areas of Access to Care, Quality of Care, and Timeliness of Care.

Strengths

Home State Health

- CLAS Task Force: The Culturally and Linguistically Appropriate Service (CLAS) Task Force is responsible for the oversight and maintenance of HSH's Cultural Competency Plan.
- Credentialing Committee: This committee is responsible for reviewing presented providers for continued delegation.
- Utilization Management Committee (UMC): UMC is responsible for reporting on authorization requirement changes and updates, UM policy updates and metrics, and network adequacy.)
- Provider Advisory Committee (PAC): The PAC is responsible for providing valuable feedback and input to help ensure Home State Health provides health care coverage that meets the needs of their members.
- HEDIS, EPSDT (Early and Periodic Screening, Diagnostic, and Treatment), CAHPS (Consumer Assessment of Healthcare Providers and Systems): The HEC workgroup is responsible for monitoring and improving HEDIS, EPSDT, and CAHPS scores and processes. This work group reviews rate trending and helps to identify any data concerns.
- Joint Operations Committees (JOC): JOCs are opportunities to meet with HSH's vendors to review contractual obligations and address any disconnects.
- Performance Improvement Team (PIT): The PIT focuses on statewide performance improvement projects which identify, develop, and implement standardized measures and interventions to optimize health outcomes for the members and improve efficiencies related to health care service delivery.
- Providers are encouraged to complete the U.S. Department of Health and Human Services Physician Practical Guide to Culturally Competent Care.
- Due to Home State Health's processes of PCP auto-assignment, there are no barriers to members receiving access to care in or out of the Home State Health's provider network upon entry into Home State Health.

Healthy Blue

- Has a Quality Improvement (QI) program that includes the objective and systematic monitoring of the quality, appropriateness, accessibility, and availability of health care and services provided to eligible MO HealthNet members.
- Member Engagement: Healthy Blue has a multi-touch approach to impact members' quality care, such as educating members on preventive services and mailing reminders. In addition, members are called through their Preventive Services Outreach program to educate them on HEDIS services due and assist them in scheduling appointments via a 3-way call with provider offices. The members are rewarded for taking personal responsibility of their health.
- Healthy Blue's Healthy Rewards Program aims at improving members' quality care, preventive health services, wellness, and engagement milestones.

- Provider Engagement: In CY 2018, Healthy Blue expanded their Quality Practice Advisors (QPA) to 6 employees. QPA, provider relations representatives and the chief medical officer (CMO) visited high-volume provider offices. During visits, the CMO provided consultations and educated providers on opportunities to improve quality care. The providers were educated on HEDIS coding, distributed HEDIS toolkits, and reviewed medical records to identify care gaps.
- Healthy Blue hired its first Patient Care Advocate (PCA) with a goal of adding 2 PCA's in CY 2019. PCA's will be embed in provider offices to help encourage members with HEDIS care gaps to come in for care.
- In CY 2018, Healthy Blue also enhanced its provider incentive program and offered them to PCPs and Behavioral Health providers. PCP Incentive Program Providers had an opportunity to earn a Bonus for closing gaps for the selected HEDIS measures.
- While there were no reported member grievances associated with segregation or discrimination, the plan tracks and trends issues such as these as a part of their quality assurance program. Providers with repeat grievances against them or quality concerns may be subject to peer review, education, and internal audits.
- Healthy Blue is in the process of earning a distinction from the NCQA in multicultural healthcare and has a work plan for its implementation.
- Healthy Blue's Supplier Diversity Program is dedicated to diversifying its supplier base to include minority-owned, women-owned, veteran-owned, LGBT (Lesbian, Gay, BiSexual, Transgender)-owned, and disabled-owned businesses wherever possible. Healthy Blue actively works to include diverse suppliers in every bidding opportunity. Healthy Blue has established a 12% Supplier Diversity goal.

United Healthcare

- UnitedHealthcare reported that in the fall of 2020, they launched a pilot program focusing on providing homeless people housing, shelters, and food.
- UnitedHealthcare prioritizes its engagement with qualified providers who promote a culturally sensitive environment and embrace the health care provider's role in minimizing health care disparities. Care Provider Manual informs the providers that UnitedHealthcare has developed a Cultural Competency Program to meet its membership needs.

Recommendations

- The MCOs must proactively develop their policies and procedures for all the regulations covered in the compliance review and not merely post snapshots/tabulate contents "as is" from the MHD contract and CFR.

EQRO Special Project: Case Management Performance Review

In 2010, the EQRO began conducting a special project related to the provision of Case Management services by the (Managed Care Health Plans) MCHPs. The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in service delivery and record keeping. This involved the evaluation of the MCHPs' compliance with the federal regulations and the Managed Care contract as it pertained to Case Management. The term "case" has been replaced by "care" in the MHD Managed Care contract (section 2.11), and hereinafter, stated as care management (CM).

The focus of this review in EQR 2022 was as follows:

- Individuals in foster care, receiving foster care or an adoption subsidy, or other out-of-home placement (hereinafter referred to as Foster Care CM)
- Children with elevated blood lead levels (EBLLs CM)
- Individuals with Autism Spectrum Disorder (Autism CM).

There are four categories for which each MCHP's Care Management program is evaluated. These contract categories include:

- Review of Care Management Policies and Procedures
- Evaluation of Care Plan
- Onsite Interviews
- Medical Record Review (MRR)

Case Record Reviews

A list of members care managed in CY 2021 for the three focus areas was submitted by each MCO. The EQRO selected a sample of 30 medical records (maximum limit: required sample size of 20, plus 50% oversample for exclusions and exceptions) by using a stratified random sampling method based on CMS EQR protocols, Appendix B. Files were uploaded using a secure file upload site. An MHD approved (Excel workbooks) was created to capture information from medical records, which included, at a minimum: referrals; assessment; medical history; psychiatric history; developmental history; medical conditions; psychosocial issues/stressors; legal issues; care planning; lab testing; progress notes/follow-up; monitoring of services and care; coordination and linking of services; the transition of care after hospitalization; transfers; and discharge plans; and case closure.

Ten percent (10%) of the medical records from each focus area were reviewed by different auditors to assess the degree of agreement in assigning a score for compliance in the evaluation tool. Criteria were used to assess inclusions, exceptions, and exclusions.

In the EQRO Case Management data request, the MCHPs were asked to submit a listing of all members identified for CM programs and those members that are enrolled in a CM program.

MCO	CM Staff Available	Average Case Load	% of Members Enrolled in a CM Program during CY 2021
Home State Health	62	77	8%
Healthy Blue	24	60-90	1%
United Healthcare	38	299	1%

Quality of Care

When members are properly introduced to and engaged in care management, the quality of service delivery improves. For example, care managers maintain contact with the members they serve throughout the care management process. Record reviews and interviews substantiate that, in some cases, the care manager advocates for extraordinary services to meet a member's health care needs.

Access to Care

Access to care was enhanced when care managers actively worked with families. The care managers of all MCOs took the initiative to call providers and confirm appointments for their members and follow up with their blood lead levels. Care managers at all MCOs need to contact a variety of sources to track members' whereabouts and make required contacts. Member demographic information continues to be a concern due to its unreliability, which hinders outreach for proper care management.

- MCOs should have a point of contact at every provider's office to discuss and share care plans.
- Different modes of outreach should be used at different times of the day and different days of the week to increase opportunities of actually reaching the member/guardian to initiate the CM process.
- Language barriers may present obstacles for the initial contact of the member/guardian.
- Home visits on EBLLs continue to be a concern. The care manager shall explain to the member/guardian about this significance and how this would help in tailoring the care plan.

Timeliness of Care

When case managers are actively serving a member, fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion.

- MCOs work to provide information about providers in addition to tracking and helping in scheduling appointments.
- Availability of Nurse Line to provide nursing advice services.

- MCOs help to provide resources and links to community resources, support services, and therapists.

Recommendations

- The health care plans should be shared with Primary Care Providers and informed about how they can provide input or change the care plan.
- Primary Care Providers should be notified about case closure per instructions in the MHD contract.
- The MCOs' CM teams should utilize the Health Information Exchange (HIE) to increase coordination, reduce fragmentation and improve overall communication between care providers. All Missouri Medicaid providers have been offered free HIE enrollment.
- Home State Health and Healthy Blue's children should receive a complete mental health evaluation, including a trauma assessment, shortly after entering foster care. A mental health screening to assess suicide risk and acute mental health needs are important at the entry to care. A complete evaluation is best conducted after the child has had time to adjust to their new living situation and visitation with the family.
- CM assessment should be completed within five business days of admission to psychiatric hospital/residential treatment facility.

Corrective action (MCO/provider level): Not applicable.

Program change (system-wide level): Not applicable.

Behavioral and Physical Health Reviews Conducted by the State Staff

In 2020, MHD updated the process of performance reviews for clinical behavioral and physical health operations performed by the MCOs and/or their subcontractors. The focus of the physical and behavioral health reviews has been placed on the member journey experience with each MCO and their subcontractors to identify and address any patterns of under- or over-utilization that would suggest issues with access to or quality of care for Managed Care enrollees.

MHD clinical staff conduct an annual clinical audit with each contracted MCO. The audits involve quarterly data submission to MHD and meetings between MHD and each health plan. The audit includes three components: member journey data, improvement plan reports, and care management (CM) chart reviews. Operational areas of focus for the audits include CM outreach and engagement, case closure, and pediatric enrollment in asthma CM. Additional areas of focus include adult enrollment in diabetes CM, enrollment in behavioral health CM following inpatient psychiatric admissions, and CM for mothers whose babies required a neonatal intensive care unit (NICU) stay or had a birthweight of less than 2,500 grams (5 pounds, 8 ounces).

MHD clinical staff review the quarterly data submitted by each health plan and develop questions to guide discussion during quarterly virtual meetings. The data set includes definitions of the

numerator and denominator for each of the journey map measures. Each health plan has identified three of the eight member journey measures for inclusion in an improvement plan. The improvement plan is required to involve ongoing efforts to improve outcomes for the health plan members.

MHD also performs an in-depth chart audit reflecting CM outreach and engagement within each health plan. Each year MHD audits charts for different diagnoses to include physical and behavioral health diagnoses, emergency room utilization, the Medicaid expansion population, etc. MHD evaluates the effectiveness of the health plans' processes for identifying members for CM outreach as well as CM enrollment rates.

Across all three contracted health plans, MHD has identified low CM enrollment rates due to barriers such as incorrect phone numbers and inability to reach members by phone. Inconsistencies were noted with risk stratification levels, notification and communication with providers, inadequate documentation for disease management, and timely identification of members with high emergency room utilization.

Health plan specific findings include:

Home State Health (HSH)

- MHD identified that HSH was utilizing auto-dialers to outreach members identified for disease management. HSH would then close the members' cases if outreach was not successful. No call was attempted by an individual prior to closing out the case.
- HSH has reported the inability to track the number of members outreached through passive mailers for members in disease management.

UnitedHealthcare Community Plan (UHC)

- UHC relies on claims data to identify members with high utilization of ED visits, which is subject to delays due to claims lag.
- Frequent data reporting errors with UHC each quarter.
- Process for identification and referral of members into their disease management program is unclear.

Healthy Blue (HB)

- Low enrollment rate into CM compared to the other health plans due to some members being placed in Care Coordination Programs that do not require a care plan.
- HB relies on claims data to identify members with high utilization of ED services, resulting in delayed identification of these members. They are currently working with a new health information exchange (HIE) for this.

- HB requires their members to opt-in to Disease Management, whereas our contract indicates that members must be auto-enrolled into DM services and must opt out if they choose to not participate.

Corrective Action (MCO/provider level): State provided recommendations to MCOs for improvement in timely identification of patterns of high ED utilization. Other issues identified above are addressed through quarterly meetings with MHD and each health plan in which health plan member journey data and improvement plans are discussed.

Program Change (system-wide level): N/A

Executive Order 98-12

The goals of EO 98-12 for the DSS and DMH to collaborate were achieved and the DSS sustains that effort.

Missouri Department of Mental Health and MO HealthNet Division Program Prescribing Practices Project

This project began in January 2003 through formal agreements between the DMH, MHD, and Comprehensive Neuroscience, now doing business as Care Management Technologies (CMT).

The goals of the project were to improve patient outcomes by improving psychiatric prescribing practices, improving continuity of care across multiple prescribers, and improving patient adherence to medication treatments for patients in the MO HealthNet program. Secondary goals included containing pharmacy costs and maintaining access to the open formulary of psychiatric medications.

The project's method and interventions are based on the following principles:

- prescribing and pharmacy utilization management decisions should be based on data instead of anecdote;
- interventions should make use of existing data sets and support the current prescribers; and interventions should be respectful of physician/patient autonomy and minimize unintended consequences. The project assumes that prescribing consistent with nationally recognized best practice standards will lower overall health care costs and that prescribers will voluntarily adhere to national standards when they know what they are.

Evidence-based and expert consensus medication practice guidelines from the peer-reviewed literature are used to identify medication prescription patterns that are usually inconsistent with best practice. Pharmacy claims from MHD are transmitted to CMT for monthly analysis to identify prescribing patterns falling outside nationally recognized best practice guidelines. The DMH Chief Clinical Officer and MHD Pharmacy Director determined areas of prescribing practice to focus educational alerts to outlier prescribers for quality improvement. Quarterly behavioral

pharmacy mailings go out to up to 2000 Adult prescribers and up to 1000 Child prescribers. Bimonthly opioid prescribing mailings are sent to up to 2000 Adult & Elderly prescribers. Each prescriber receives a cover letter identifying areas of prescribing concern, patient-specific information, educational monographs describing the relevant best practice guideline(s) and a behavioral pharmacy prescriber-specific benchmark report which provider's information to the prescriber about his/her practice pattern compared to their peers. In addition, the project alerts all Missouri physicians of patients who failed to refill key behavioral health medications in a timely fashion or were prescribed multiple drugs of the same chemical class concurrently from different physicians. Prescribers also receive a report of all psychiatric medications their patients have received in the previous 90 days, including date, dosage, prescriber (including those other than themselves) and dispensing pharmacy. Prescribers are offered telephone consultation by psychiatrists with specific psychopharmacology expertise. An additional and more focused intervention targets prescribers of antipsychotic medications to children, providing them with comparative data for their particular practice vs. those of their Missouri peers, including data on the size of the practice, number of child patients receiving antipsychotic medications, number of antipsychotic scripts written, and associated percentages for these. Percentile rankings within their peer group for these measures are also provided.

This innovative partnership was the first of its kind in the nation, winning the American Psychiatric Association's (APA) Bronze Achievement Award in 2006 and a Utilization Review Accreditation Commission (URAC) Best Practices Silver Award in 2008. The partnership has successfully improved the quality of psychiatric prescribing by both psychiatrists and primary care prescribers and has demonstrated improved clinical outcomes and cost savings. The partnership is widely recognized as a national innovation and has been rapidly replicated throughout the nation. It has continuously improved its method and continues to implement innovative new approaches.

Successes of the Behavioral Pharmacy Management Program include ongoing savings in behavioral pharmacy spend and in hospital and ED costs for intervened patients. For the time period Jan 2014-Sept 2015:

- Total estimated savings of $23.17 million in behavioral pharmacy, hospital and ER costs for the 9,826 adult and child patients who received an intervention.
- This is an average combined savings of $184 per intervened patient per month.

Successes of the Opioid Prescription Intervention Program (OPI) for the Feb 2014 – June 2015 time period include:

- Estimated annual savings of $455,392 in opioid pharmacy cost avoidance. This is an average of $11.87 per intervened patient per month.
- Significant pre-post decreases in emergency department visits (by 28.6%) and hospital admissions (by 23.5%) for intervened patients.
- Average monthly morphine equivalent (ME) dose of prescribed opioids decreased by 11.2%

Successes of the Child Antipsychotic Prevalence Program include:

- A decrease in the rate of antipsychotic prescribing to children of 20.8% for FY2015.

Health Home Initiative

In 2010 the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services released guidance on implementation of section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions."

Section 2703 adds section 1945 to the Social Security Act to allow states to elect an option under the Medicaid State Plan in which states can address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness. To achieve the full integration of care for individuals with chronic health conditions, Missouri's MO HealthNet Division (MHD) partnered with the Office of the Chief Clinical Officer of the Department of Mental Health (DMH) to plan and implement Health Homes in Missouri.

The former Chief Clinical Officer for the DMH, and former Division Director for the MHD, convened a group of critical partners including the Coalition for Community Behavioral Healthcare (newly named Missouri Behavioral Health Council), the Missouri Primary Care Association as well as the Missouri Foundation for Health to create a comprehensive model that builds on the strengths of both the public mental health system as well as the system of primary care providers to achieve integrated health management through a health home for MO HealthNet participants with complex chronic health conditions. To meet this goal, two separate though connected models were developed, and respective state plan amendments were developed and submitted to CMS. The Community Mental Health Center Healthcare Home (CMHC HCH) model was the first state plan amendment submitted to CMS, as well as the first approved.

The Primary Care Health Home (PCHH) state plan amendment was submitted shortly thereafter and was approved on December 23, 2011. Twenty-four organizations were originally approved to provide PCHH services at over eighty clinic sites throughout Missouri. Providers implemented services between January and April 2012. Twenty-nine CMHC HCHs began providing services in January 2012. Currently, there are 28 CMHC HCHs providing services. In 2014, MHD reopened the PCHH provider application process, which resulted in 32 organizations providing PCHH services at over 100 clinic sites throughout Missouri. MHD opened the application process for PCHH providers again in 2016, expanding to 35 provider organizations, and again in 2018 and 2021. After the COVID-19 Public Health Emergency, a larger organization absorbed smaller health care agencies, which brings the total current number of participating organizations to 42 that provide PCHH services in more than 208 clinic sites in Missouri.

In June 2016, the state submitted a CMHC Health Home SPA to CMS to add "chronic obstructive pulmonary disease" as a chronic condition. This SPA was approved in December 2016 with an effective date of June 1, 2016. In September 2019, the state submitted a CMHC Health Home

SPA to CMS to reflect a 1.5% rate increase granted by the MO State Legislature which was approved in November 2019. In October 20212, the CMHC HCH SPA was sent to CMS for review to add Complex Trauma as a qualifying condition, update the Primary Care Physician Consultant to the Specialized Healthcare Consultant. There was also a request to reduce the Per Member Per Month (PMPM) payment due to no longer utilizing a Primary Care Physician for all participants in the program and replacing it with a lesser-salaried position.

In June 2016, the Primary Care Health Homes at MHD submitted an amended SPA to add obesity (adult or pediatric) and pediatric asthma as stand-alone qualifying conditions, and to add depression, anxiety and substance use disorder as one of two or more qualifying conditions. This SPA was approved in June 2016. In July 2019, an amended SPA was submitted to CMS to add chronic pain as a stand-alone qualifying condition or risk factor for other qualifying conditions for PCHH. It was approved in August 2019. A second SPA was submitted in September 2019 to reflect a 1.5% rate increase mandated by the Missouri Department of Social Services and was approved November 2019. In 2023, MHD developed an add-on PMPM SPA to aid in the support of medically complex participants, allowing for added benefits to address social determinants of health and improve care coordination.

A Health Home is a place where individuals can go throughout their lifetime to have their healthcare needs identified and coordinated, including medical, behavioral, acute and chronic health care needs. Treatment and support are provided through an integrated, holistic approach to maximize the potential for positive health outcomes. Research has shown that individuals with serious behavioral health conditions, on average, die 25 years earlier than the general population. Additionally, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary or infectious diseases. At the same time, individuals with chronic physical health conditions often develop behavioral health issues such as depression, anxiety and substance use disorders.

Creation and implementation of Health Homes in Missouri follows and builds upon previous initiatives implemented through ongoing collaborations between MHD and DMH. Such initiatives include development of Health Information Technology (HIT), such as the Behavior Pharmacy Program, as well as Disease Management (DM) and Medication Adherence reports; FQHC/CMHC collaborations; the Chronic Care Improvement Program (CCIP), and wellness initiatives such as metabolic syndrome screening and the Disease Management Projects. Currently, the Department of Mental Health maintains an electronic web-based health management tool for care management, care coordination, and population health. This tool provides a comprehensive view of the individuals' medical and behavioral health, including integration of alerts, metabolic trends, patient histories based on Medicaid claims (diagnoses, procedures, pharmacy), hallmark events (ER visits, hospitalizations), and care team members. The tool also provides for customized reporting on any data within the system and provides a dashboard of quality measures for providers to use to identify needed interventions. Health Homes target individuals with chronic health conditions, particularly serious mental illness, diabetes, cardiovascular disease, asthma and chronic obstructive pulmonary disease, obesity, tobacco use, substance use and developmental disabilities. Functions of a health home include care management and coordination, providing

health and wellness education, assuring receipt of preventive services and primary care, assurance that consumers with chronic health conditions receive the medical care they need and assistance in management of their illness, facilitating and managing transitions of care (e.g. following up after emergency department visits and inpatient stays to assist with follow-up care, discharge planning and medication reconciliation), use of health technologies and access to education and supports for families.

MHD, DMH and the Missouri Institute of Mental Health (MIMH) are currently working on papers describing the clinical and utilization outcomes of both the CMHC and PC Health Home programs. The papers have been submitted for publication as journal articles. While none of the papers have been published, program evaluation is ongoing for both Health Homes, with disease-specific health outcomes being measured (e.g., reduced rates of stroke, avoidable hospitalizations, etc.). Outcomes to date include a reduction in emergency department and hospital use, and also clinically significant improvements in clinical measures (such as LDL cholesterol level, HgB A1C (for diabetes), and blood pressure),

Funding for implementation of this initiative is provided through a per-member/per-month (PMPM) payment paid by the MHD to support additional staff dedicated to the health home functions, HIT tools, and administrative support. Additionally, for the first eight (8) quarters of implementation (through December 2013), the state received an enhanced federal match for all health home PMPMs. For the Community Mental Health Center model, dedicated staff for the health home includes a Healthcare Home Director, Primary Care Physician Consultant, Nurse Care Managers, and Care Coordinator. For the primary care health home model, dedicated staff includes a Health Home Director, Nurse Care Managers, Behavioral Health Consultant, and Care Coordinator. MHD conducted a pilot project in southwest Missouri to determine the benefits of adding community health workers (CHWs) to the PCHH care team. CHWs function as care coordinators and as a community-based extension of the care coordination already provided by the Primary Care Health Home. These CHWs work with individuals who have "high utilization" (of emergency rooms and hospitals) and high-risk PCHH participants in their homes and in the community, and focus on helping them address social determinants impacting their health and well-being, as well as health care services utilization. The pilot showed that the addition of CHWs resulted in improved outcomes over a shorter time period than outcomes shown by the "basic" health home. MHD is looking at how to sustain CHW services and currently supports over 50 CHWs at 29 Federally Qualified Health Care Centers (FQHCs).

Data on specific performance indicators are being captured and include clinical measures, process measures, appropriate prescribing indicators, as well as medication adherence data; outcomes from metabolic screening; use of appropriate health technology, including CyberAccess; hospital admissions and visits to emergency departments, as well as related transition and coordination within the community; substance use disorder; and tobacco use. MHD and DMH continue to enhance the Health Home initiative through enhancements to performance measures as indicated; ongoing provider education through care team forums, DVDs, learning collaboratives, provider conference calls and webinars; and continued work with CMS to improve performance and enhance outcomes and efficiencies.

The Departments of Mental Health and Social Services collaborate closely on the implementation and evaluation of the health home initiatives. Operations meetings with staff from both departments are held regularly, as are financial and clinical evaluation meetings.

The PCHH program manager participates in leadership team and operational meetings for the CMHC HCH, and the CMHC program manager participates in those meetings for the PCHH initiative. The leadership of both initiatives is committed to operating the two initiatives as similarly as possible when overlapping processes exist, and work together to address issues that involve both initiatives. Likewise, MHD and DMH leadership encourage the PCHH and CMHC HHs to work together on the management and coordination of care of shared patients.

Health Home Model	Number of Members *
PCHH	35,212
CMHC HCH	27,989

*As of 01/01/2024

The CMHC State Plan Amendment (SPA) was approved 10/20/11 and the amended SPA was approved December 22, 2016. The SPA that includes the 1.5% rate increase was approved by CMS in November 2019.

The Primary Care SPA was approved 12/22/11, and the amended SPAs were approved on 06/12/2017, 08/15/2019, and 07/01/2023.

Strategy: Statewide Performance Improvement Projects

RESPONSE:

MCO

Source: Statewide Performance Improvement Project Task Force

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Statewide Performance Improvement Project

Oral Health Statewide PIP

Based on a 2008 site visit at the Department of Social Services/MO HealthNet Division (DSS/MHD) conducted by the Centers for Medicare & Medicaid Services (CMS) and a subsequent

site visit report, the state decided to initiate a statewide Performance Improvement Project (PIP) for oral health. The Dental Task Force, formed in September 2009, provides the forum for collaboration between the MCOs to improve dental care to the Managed Care population.

The Dental Task Force is composed of representatives from the MHD, MCOs, the Missouri Coalition for Oral Health, the Missouri Dental Association, the External Quality Review Organization, the Missouri Department of Health and Senior Services, Missouri's Dental Director, and Legal Services of Missouri (advocates for Managed Care members).

The MCOs project provides comprehensive dental care as a part of the EPSDT benefit. All dental services are covered, including diagnostic care, as well as all necessary treatment and follow-up care. Dental benefits are covered for all members from birth through age twenty (20) and for all pregnant women. Additionally, dental coverage was added for adult members beginning January 1, 2016.

In 2018, the potential barriers for access to dental care remained unchanged from earlier years and continue to include the following:

- Provider participation – Fewer dentists are participating in the Medicaid program.
- Reimbursement rates – The reimbursement by Medicaid does not meet the cost of many of the dental services that are provided.
- Administrative Issues
  - Complex enrollment forms
  - Non-standard billing forms
  - Excessive prior authorization requirements
  - Slow payments
  - Inefficient eligibility determinations
- No Shows – According to the American Dental Association (ADA), one-third of Medicaid dental appointments result in 'no shows'. For families with Medicaid-eligible children, a lack of reliable transportation to the dental office and difficulties arranging for child care or leave from work often lead to missed appointments.
- Geographical Barriers – Competitive market to keep dentists practicing in their locale.
- Personal Behaviors – Parents may not be familiar with the dental delivery system and may not recognize the value of preventive dental care because of their own poor history of dental care.

Since the implementation of the PIP, the MCOs have instituted various initiatives as noted below:

- Worked with dental subcontractors to redirect members who visited the ER for dental reasons back to their dentist.
- Provided information on EPSDT requirements and dental information on improving oral health to school nurses.
- Included articles on oral health in their summer newsletter.

- Maintained MCO websites with updated oral health and wellness information.
- Reviewed medical records to target providers who did not refer members for dental visits as part of their EPSDT visit.
- Collaborated with dental subcontractors to improve HEDIS rates utilizing an initial postcard for all non-compliant members with a follow-up call if dental visit has not occurred 60 days after postcard mailing.
- Collaborated with dental subcontractors and visited provider clinics for outreach in getting more members in dental chairs.
- Provided outreach to Head Start programs.
- Utilized provider toolkit to educate providers on the State Dental Plan, the current HEDIS rates, and the goal to increase by 3% the number of children who receive annual dental visits.
- Member notification reminder of services due.
- Added dental reminder to wait/hold message.
- Set up mobile dental units to travel to schools to treat children on-site.
- Robust texting campaigns to remind members of needed annual dental visits.
- Targeted outbound call campaigns for noncompliant members' annual dental visits.

The original focus of the Oral Health Statewide PIP was to increase the number of eligible members ages 2 through 20 years old by 3% between calendar year 2009 and calendar year 2010. In July 2019, MHD released a revised Performance Withhold Program, which included the HEDIS measure for Annual Dental Visits, which focused on the percentage of members 2-20 years of age who had at least one dental visit during the measurement year. Due to this, the MCO PIP aim was revised to increase the Annual Dental Visit total rates by three percentage points instead of three percent. While Annual Dental Visit rates have increased fairly steadily since 2016, the improvements have generally fallen short of the desired 3% annual increase. HEDIS 2019 (CY2018) rates showed significant improvement. However, HEDIS Measurement Year 2020 had a large decrease from 2019 rates, attributable to the COVID-19 pandemic and associated decreases in healthcare utilization across the board in 2020. These decreases continued into 2021. Rates begin to trend back upward in 2022.

NOTE: 2017 and 2018 data only include Healthy Blue and Home State Health. United Healthcare did not have HEDIS data until 2019.

% of Members with Dental Visits (Ages 2-20)	
2017	43.44%
2018	45.04%
2019	49.59%
2020	55.37%
2021	42.32%
2022	43.36%

Corrective action (MCO/provider level): Not applicable.

Program change (system-wide level): Not applicable

Strategy: Performance Measures

RESPONSE:

MCO

Source: **MCO HEDIS measures reported to Missouri Department of Health and Senior Services and to MHD**

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

MO HealthNet Managed Care Performance Measures are required to be reported in accordance with HEDIS specifications to the Department of Health and Senior Services (DHSS) and MO HealthNet Division (MHD) per state regulation 19 CSR 10-5.010 and the MO HealthNet Managed Care contract. Both DHSS and MHD analyze the performance measures to compare MCOs' performance to the statewide and NCQA national average.

Detailed bar charts for HEDIS measures are found on Appendix C Monitoring Performance Measures of this document. In these charts the percent on the "Statewide Averages" indicates the average percent of all MHD MCOs for each indicator. The "NCQA Average" indicates the national average for Medicaid, all lines of business.

Problems identified: None

Corrective action (MCO/provider level): Not applicable.

Program change (system-wide level): Not applicable.

Strategy: Test 24/7 PCP Availability

RESPONSE:

MCO

Source: MO HealthNet Managed Care Health Plan 2022 Annual Reports.

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

Each MCO reviewed 24/7 availability for their PCPs, either through an audit (Home State and Healthy Blue) or a provider survey (United Healthcare). Results are as follows:

Health Plan	# PCPs Surveyed/Audited	% PCPs with 24/7 Availability	After-Hours Coverage Methods
Home State	291	92.00%	Answering Machine Answering Service
Healthy Blue	N/A	85.00%	Answering Machine Answering Service
United Healthcare	478	83.00%	Answering Machine Answering Service

While answering machine messages generally provide instructions on how to access urgent or emergency care after hours, many PCPs can be reached after hours through paging by their answering services, and some providers leave instructions on their answering machine message regarding how to have the provider return urgent after-hours calls.

Additionally, annual CAHPS surveys from the three MCOs reveal high rates of member satisfaction regarding after-hours access to care:

Health Plan	CAHPS Rate for "Getting Care Quickly" (% 'Usually' or 'Always')
Home State	88.60%
Healthy Blue	90.31%
United Healthcare	89.10%

Strategy: Utilization Review

Sources: HEDIS calendar years 2016-2022; Health Plans CY2022 Annual Evaluation Reports; provider data submitted by the MCO's to the Missouri Department of Health and Senior Services (DHSS); Maternal and Child Health Indicators and Trends Report 2022.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

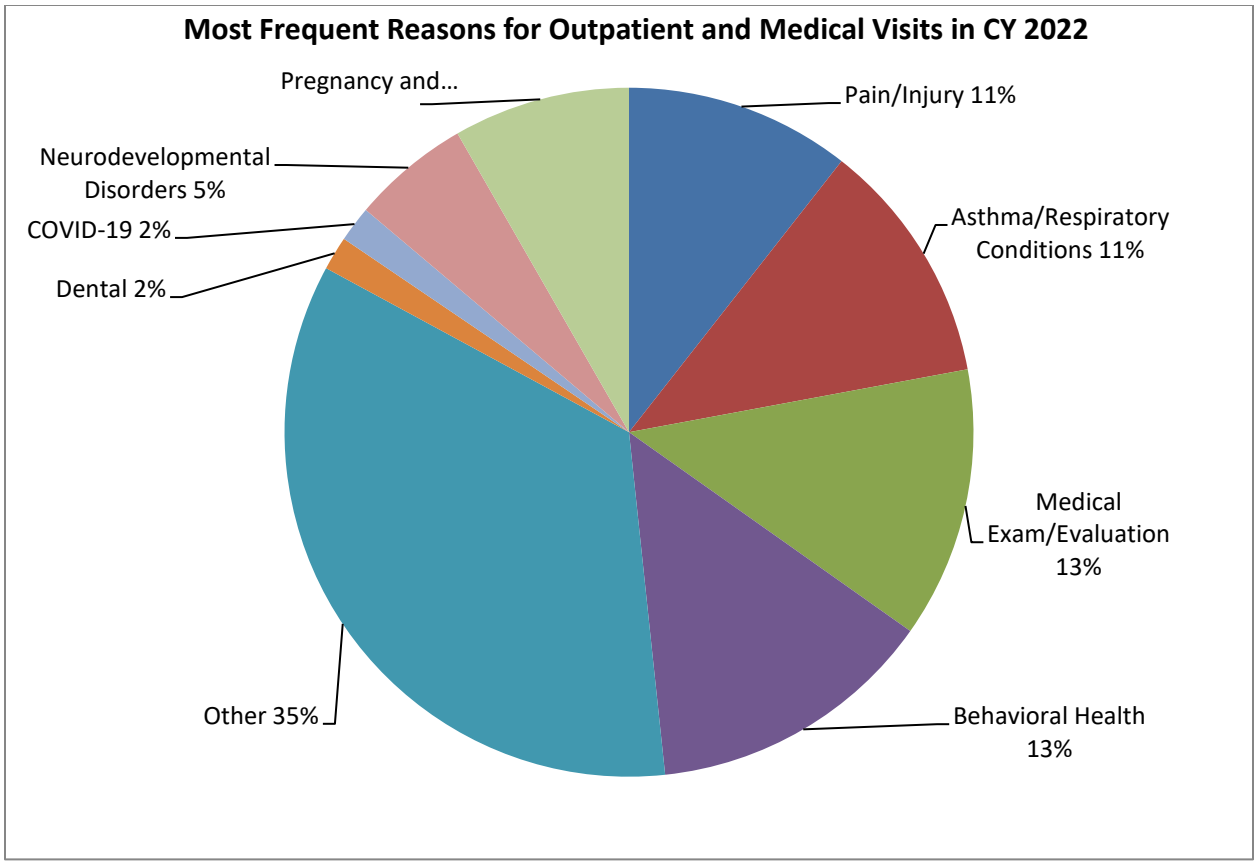
Summary of results:

Detailed charts for HEDIS measures are found on Appendix C Utilization Review of this document.

Outpatient and Medical Encounters

The top thirty International Classification of Diseases, Tenth Revision (ICD-10) codes in the first diagnosis field on the outpatient and medical encounter claim file layout were grouped into nine categories that represented 53.6% of all outpatient and medical encounters for services provided in CY 2021. Of these top thirty diagnosis codes the majority of outpatient encounters were for "Other" diagnosis (35%), followed by "Behavioral Health" (13%), "Medical Exam/Evaluation" (13%), "Asthma/Respiratory Conditions" (11%), "Pain/Injury" (11%), "Pregnancy and Childbirth" conditions (8%), and Neurodevelopmental Disorders (5%), COVID-19 (2%).

The category "Other" was comprised of ICD-10 codes such as factors influencing health care, unclassified conditions, diseases of the heart, of female genital organs and of the urinary system, other skin disorders, ear and eye disorders, etc**.**

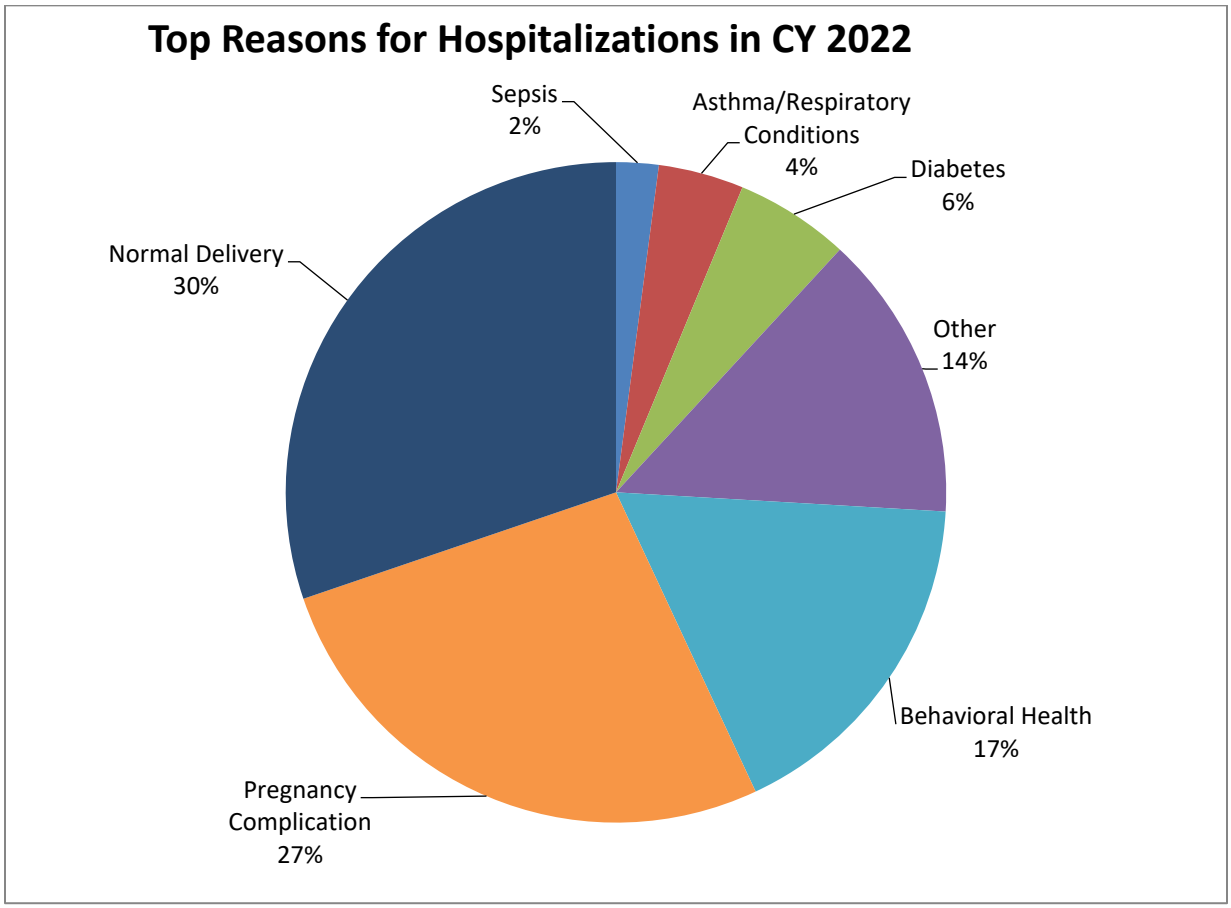


Source: Missouri Department of Social Services, MO HealthNet Division

Inpatient Encounters

The top thirty International Classification of Diseases, Tenth Revision (ICD-10) codes in the first diagnosis field on the inpatient encounter claim file layout were grouped into seven categories that represented 69.58% of all inpatient encounters for services provided in CY 2021. Of these top thirty diagnosis codes the majority of inpatient encounters were related to "Normal Delivery" (30%) followed by "Pregnancy Complications" (27%), "Behavioral Health" (17%), "Other" (14%), Diabetes (6%), Asthma and Other Respiratory Conditions" (4%), Sepsis (2%).

The category "Other" was comprised of ICD-10 codes such as diseases of the urinary system, skin infections, epilepsy, gastrointestinal disorders, anemia, fractures, heart disease, etc.



Source: Missouri Department of Social Services, MO HealthNet

Dental Service Utilization

Under their contracts to provide health services to Managed Care enrollees, MCOs are required to provide dental services. The Managed Care Policy Statement for Dental Services outlines the

MCOs' responsibilities for these services. The policy states that "MCOs must conduct EPSDT screens on enrollees under the age of 21 to identify health and developmental problems. It is recommended that preventive dental services and oral treatment for children begin at age 6 to 12 months and be repeated every six months or as medically indicated". Although an oral screening may be part of a physical examination, the DHHS and the CMS state that an oral screening does not substitute for an examination through direct referral to a dentist (Source: MO HealthNet Managed Care Policy Statements, Dental).

In the Managed Care Program, the MCOs currently delegate dental services to Dental Benefit Management Organizations (BMO's), and they are responsible for ensuring that state requirements and health care needs for MO HealthNet Managed Care enrollees are met.

MCO Dental Benefit Management Organizations

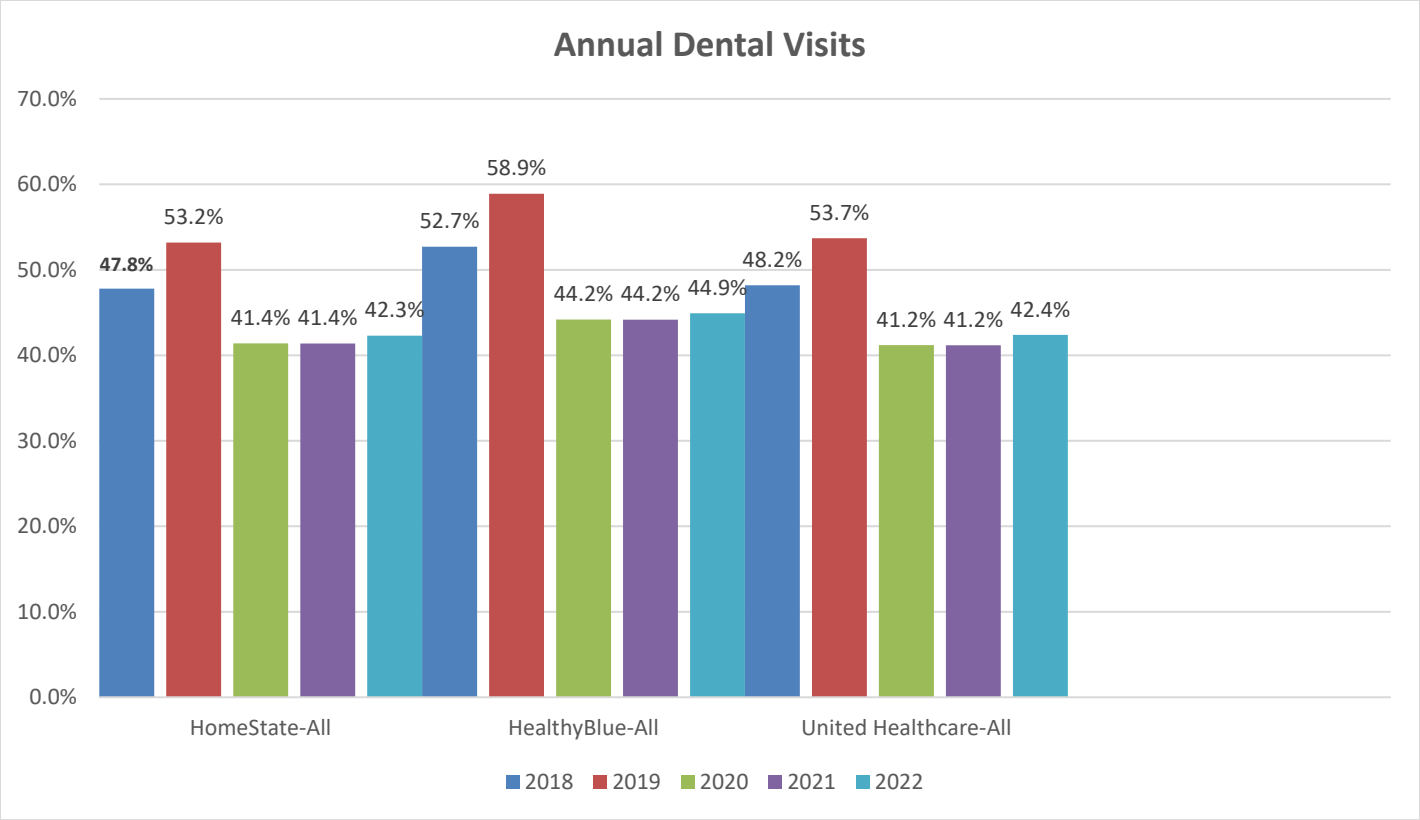
MCO - Eastern, Central, Western and Southwestern Regions	Dental Plan
Home State Health Plan	Envolve Dental (DHW)
Healthy Blue	DentaQuest
United Healthcare	Dental Benefit Partners

Several sources of data were reviewed to examine the access and use of dental services among MO HealthNet Managed Care enrollees. First, a state mandated reporting indicator for annual dental visits was examined. Second, the adequacy of MCO dental provider networks was examined.

Annual Dental Visit Rates

The MCOs must report annual dental examination rates to the Department of Health and Senior Services (DHSS) on an annual basis. Rates are based on HEDIS calculations of the proportion of MO HealthNet Managed Care enrollees who were 2 to 20 years of age, continuously enrolled during the measurement year, and who had at least one dental visit during the measurement year.

The HEDIS Measurement Year 2022 MCO rates for annual dental visits ranged from 41.4% to 47.3% for the three MCOs. Due to the COVID-19 pandemic healthcare utilization across the board has decreased since CY2019. The chart below illustrates the annual dental visit/examination rates for each of the MCOs from CY2020 to CY2022.



Home State

HSH contracts with Envolve Dental, a Centene subsidiary, to provide the dental network and administers the dental benefit for our members. In 2020, Home State held quarterly Joint Operating Committee (JOC) meetings with Envolve Dental. Regular JOC topics include authorizations, metrics, providers, care gaps, and claims. Envolve Dental credentials its providers, pays claims, and handles the utilization management and appeals of denied services.

Since the inception of HSH's oral health PIP there have been initiatives implemented to improve the oral health of our members. HSH's EPSDT program includes outreach to members at strategic milestones, encouraging their engagement in wellness activities, including oral health. Through monthly assessment of member engagement, HSH outreaches members who have not completed their annual dental visits in multiple ways:

- Live and automated telephonic outreach,
- Member Services interactions,
- Care Management interactions,
- Texting program, and
- Marketing activities such as health fairs

Home State Health is committed to providing an integrated care delivery model and believes that this approach will increase member access to care and overall improved wellness. The oral health initiatives implemented are an integral part of this strategy. In addition to integrating services, the focus will be on innovative ways to educate and empower members to take part in their oral health. The ongoing activities are expected to have a positive impact on HSH's ADV rates. Additionally, HSH implemented two interventions, AlphaPointe and texting, to improve the ADV compliance rate.

Home State Health contracted with AlphaPointe, a sheltered workshop in Missouri, to call members regarding care gaps. In January, November and December of 2019, AlphaPointe was provided with a list of members who were not compliant with the ADV measure. They attempted to place calls to 41,006 members to remind them of their dental benefit. If they were able to reach the member, they informed them of their dental benefit, the availability of an incentive on their rewards card for completion of a dental visit, and, if applicable, the transportation benefit.

AlphaPointe provided HSH with the outcome of their attempts to reach members in a summary format. In 2019, AlphaPointe also made calls to members related to EPSDT (Early and Periodic Screening, Diagnostic, and Treatment). While the EPSDT calls were not specifically designed to address ADV, physicians routinely discuss the importance of a dental visit when the members attend their EPSDT visit. These EPSDT calls, however, were not a formal intervention for this ADV PIP and were not analyzed.

Plan for Sustained Improvement Home State Health will continue to fully participate and collaborate with the Missouri Dental Task Force to develop innovative methods to provide dental services to the eligible population. HSH believes that the Quality Improvement Team's efforts in both HEDIS and EPSDT member outreach as well as the collaboration with the Missouri Coalition for Oral Health (MCOH) and the Missouri Department of Health and Senior Services (DHSS) implementation of Women, Infants and Children (WIC) Program-based oral health services, will contribute to future improvement in ADV rates.

Improving Oral Health (PIP):

By increasing annual dental visits, Healthy Blue's members have an improvement in their oral health. In addition, receiving the right care in the right setting can result in a reduction in Emergency Department visits for issues that could be resolved in an outpatient setting, such as dental health issues.

United Healthcare

In 2018, the QI Program participated in development of a provider incentive program which began in January 2019 involving Annual Dental Visits (ADV). The dental vendor for United Healthcare was Optum. In 2022, UHC's dental vendor is Dental Benefit Partners (DBP).

The dental vendor works with UHCCP MO to assist with the PIP for increasing the percentage of UHCCP MO members between ages 2-20 years old who are eligible for and receive an annual dental visit and HEDIS® measure improvement as needed.

Encounters Data
UHCCP MO's dental vendor submits encounters data on at least a monthly or more frequent basis. The dental vendor has shown consistent, timely submission to allow for encounters to be submitted in within the 30 days from claim payment requirement.

Any time encounter acceptance rates fall below the 98% contractual requirement operations and encounter teams work both with our vendor and state partners to identify the issues causing the rejections and take the appropriate actions to remediate the problems.

Prior Authorization Denials
UHCCP MO's dental vendor has prior authorization requirements for certain services. The total number of prior authorization requests has steadily increased since the plan inception while the percentage of denied prior authorizations has steadily decreased. In 2020, there was a slight decline in prior authorization requests for the first two quarters due to COVID-19, but this picked back up and was at its highest in Q4 2020. The dental vendor began with a prior authorization denial just over 14% at the inception of the plan and has remained fairly steady, with the average denial rate for 2022 being 14.98%.

Timely Payment
UHCCP MO's dental vendor is responsible for the timely payment of claims. All clean claims are to be paid within 30 days and the vendor has been compliant with this. All unclean claims are to be processed within 45 days and the vendor has been compliant with this as well. The dental vendor's average turnaround time to process claims has decreased overall since plan go-live average of 11.27 days. Q3-2022 average turnaround time was at 5.35.

Analysis: The dental vendor maintains a good relationship with UHCCP MO and met established performance requirements related to quality in 2022.

Action Plan: UHCCP MO will continue to collaborate with the dental vendor to improve preventive service utilization and overall outcomes. Additionally, we will continue to monitor quality metrics for the dental vendor to identify any areas of concern or additional areas for improvement.

Case Management

The State of Missouri defines case management as services focusing on enhancing and coordinating an enrollee's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; insuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points

for individual members; addressing and resolving patterns of issues that have negative quality cost impact; and creating opportunities and systems to enhance outcomes.

MCOs receive guidance from the Managed Care contract and the Federal Medicaid Managed Care rules to assist them in developing case management services for Managed Care enrollees. The emphasis of this guidance is to improve health status through the coordination of individual Managed Care enrollee health care needs. All of the MCOs monitor high-risk Managed Care enrollees by employing specialized nurses who have regular contact with Managed Care enrollees to perform case management. The MCOs are required by contract to notify members via the member handbook that they may request case management services at any time.

The MCOs are required to perform an assessment for case management for new members who present with special health care needs. The following groups of individuals are at high risk of having a special health care need and are sent to the MCOs on a monthly basis:

- Individuals with Autism Spectrum Disorder;
- Individuals eligible for Supplemental Security Income (SSI);
- Individuals in foster care or other out-of-home placement;
- Individuals receiving foster care or adoption subsidy; and,
- Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state agency in terms of either program participant or special health care needs.

Home State

Home State Health has an integrated Case Management Model. Home State Health treats the member as a whole. Home State Health (HSH) adheres to the Case Management Society of America's (CMSA) definition of case management: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and quality cost-effective outcomes". HSH also abides by the principles of case management practice, as described in CMSA's most recent version of the Standards of Practice for Case Management, revised in 2016. Home State Health provides both episodic and complex care management, based on member needs and the intensity of service required. Per Section 2 of the MO HealthNet Contract, HSH shall provide care management to selected members. Home State Health trains and utilizes motivational interviewing techniques to guide member goal identification and actions.

Levels of case management
Care coordination – appropriate for members with primarily psychosocial issues, such as housing, financial, etc., with a need for referrals to community resources or assistance with accessing health

care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor medical or behavioral health concerns arise.

Case management – appropriate for members needing a higher level of service, with clinical needs. Members in case management may have a complex condition or multiple comorbidities that are generally well-managed. Members in case management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a case manager.

Complex case management – a high level of case management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those who are frail, elderly, disabled, or at the end of life. Complex case management is performed by HSH for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Services at this level of complex care management include all coordination and care management services from above, along with a more frequent outreach to the member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor members' key indicators of disease progress.

Mission of the HSH Care Management Program

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist members in determining and accessing available benefits and resources.
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals.
- Assist members by facilitating the timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

Goals of Care Management Program

Measure	Goal	Frequency
Member experience survey	> 90% Satisfied	Annual
Member complaints/grievances	< 1/1,000	Annual
Reduce Non-Emergent ER Visits	> 3%	Annual
Reduce Readmissions	<9.3%	Annual

For 2022, out of 58 members who responded to the question "How happy are you with the Care Management Program," 57 were very happy or happy. Therefore, 98.3% of the members surveyed reported satisfaction with care management, meeting the annual goal.

Home State Health (HSH) monitors and analyzes continuity and coordination of care between medical and behavioral health care annually. Continuity and coordination of care between medical and behavioral health care is monitored by a collaborative workgroup including members of the HSH Provider Relations, Medical Management, Member Services, and Quality Improvement departments, as well as collaboration with the MBHO. HSH assesses the following areas of collaboration between medical and behavioral health care:

- Exchange of information between behavioral health care and primary care practitioners and other relevant medical delivery system practitioners or providers.
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care.
- Management of treatment access and follow-up for patients with coexisting medical and behavioral disorders.
- Primary or secondary preventive behavioral healthcare program implementation.
- Special needs of members with severe and persistent mental illness.

Healthy Blue

Objectives:
• To ensure members with behavioral and complex medical needs receive appropriate integrated care and coordination of needed services
• To monitor and take action as necessary, to improve coordination between two medical settings and between medical care and behavioral healthcare.
• To ensure that member needs are addressed with a whole person approach, with consideration for physical, behavioral and social needs.
• To provide support to members through partnerships with providers, caregivers and community services

Goals:
• Reduce the amount of identified members who opt out of the program by 2%.
• Enroll at a minimum 20% of members referred to case management.
The Care Management program was available to all enrolled members when determined to be medically necessary.
• Increase the level of BH PH integration and collaboration across respective care management programs.
• Implement activities to improve coordination of care across the network between two medical settings and between medical care and behavioral healthcare.

Findings:

• The number of identified members to opt out of the care management program rose to 2%, which exceeded our target. While Care management received training on techniques for motivational interviewing and scripting for member engagement, scripting related to the centralized PHS may have contributed to the "depersonalization" of the care coordinator interaction. The care coordinators (outside of OB) no longer conduct any screening, thereby decreasing the ability to develop a relationship during the call.
• The total enrollment for all members identified for care management is 20.62%, with 56.06% unable to contact. The most common reason for lack of enrollment remains, by far, inability to reach members.

Members with special health care needs are outreached within the time frames set by the state.

Types of Members Referred/Managed in Integrated Case Management by Condition/Disorder
Catastrophic
Special Health Care Needs
Complex Discharge Needs
Multiple Co-morbid Chronic Medical or Behavioral Health Conditions Such as COPD, CHF, CAD, Diabetes, HIV/AIDS, Depression
Solid Organ and Tissue Transplants
High Utilization
Member has one of the following medical or behavioral health chronic conditions: CHF, Asthma, HIV/AIDS, Diabetes, CAD, Hemophilia, Sickle Cell Anemia, Depression, Anxiety
High Risk OB and OB
Serious mental illness
Lead Toxicity
Wounds

Quantitative Analysis:

Care Management	Goal	2020	2021	2022	Goal Met
Total Members in Care Management	**Monitor**	5056	3828	**5456**	n/a
Total New Care Management Cases	**Monitor**	4206	4171	**8,967**	n/a
Total Open CM Cases/Case Manager Includes Lead, Perinatal, BH, and Physical Health	**40-50**	50+	50+	**50+**	Yes
Total CM Enrollment % (% Members Enrolled in CM)	**2.5%**	1.45%	1.26%	**2.7%**	No
CM Enrollment of Referred Members % of Referred Members to CM that were Enrolled in CM	**20%**	25.75%	22.40%	**20.62%**	Yes
Opt-out Rate of CM Members (% of CM Members who Opted-Out)	**<10**	13.41%	12.9%	**8.27%**	No
CM Case Closed: Unable to Contact (Number of Member Unable to Contact)	**<50%**	52.81%	47.5%	**56.06%**	Yes

- The CM enrollment rate declined by 1.78 percentage points in 2022.
- Opt-out Rate of CM Members decreased from 12.9% to 8.27% in 2022.
- The Unable the Contact rate increased from 47.5% to 56.06% in 2022.

Accomplishments/Actions Taken:

The Care Management program was available to all enrolled members when determined to be medically necessary. We identified potential candidates for enrollment in care management through the following processes and strategies:

- Algorithm which was redesigned to identify and stratify members based on several factors including diagnosis, cost, utilization and risk
- ED Trigger Reports
- Information provided from the health risk questionnaire, Internal and external (e.g., waiver programs) MO HealthNet referrals, screenings of members, including Welcome Calls, prior authorization, concurrent review, Customer Service
- Referrals from our network of providers, MO HealthNet, advocacy groups, schools, community-based organizations, as well as members and their families
- Whole health initiatives in 2022 Care Management focused on members with Asthma, Diabetes, and Maternity related initiatives.

By employing the identification strategies above, CM staff were able to successfully identify, at a minimum, those members whom the state requires be offered or assessed for case management, such as:

- Pregnant members (including those with substance abuse issues)
- Children with elevated lead levels equal to or above 3.5 μg/dL, exceeding contract requirements
- New member with specific diagnosis/existing member who receives new diagnosis (e.g., cancer, cardiac disease)
- Members with special health care needs including those with autism spectrum disorder. Members in foster care also were included in specialized Care Management
- Members experiencing certain events that put them at risk (e.g., high ED utilization for physical and/or behavioral health conditions, residing in foster care placement)
- Members admitted to a psychiatric hospital or residential substance abuse treatment program

By following the identification and assessment process, Healthy Blue's care managers worked collaboratively with the member, the member's caregiver, PCP, specialist providers and other stakeholders, as appropriate, to tailor an individualized care plan including mutually agreed upon prioritized goals.

Care managers contact members based on the member's needs, but the minimum is at least once per month. The care manager and member, including member supports like family and providers, agree on a health goal(s) and work together to achieve the goal(s) utilizing local resources, if needed. All activity is member-centric. The member's health care provider is sent the care plan

that includes goals and interventions. Care managers regularly evaluate and revise care plans to assess effectiveness and to provide feedback to the member, the member's caregivers and his or her health provider(s) of health care services. The objective of this process is to determine the level of compliance with the care plan and the degree to which the member was attaining mutually agreed-upon goals. The process also allows care managers to identify any new barriers encountered by members and to provide intervention. The evaluation process incorporates a certain degree of flexibility because a member's situation and needs often change. The process also considers the member's stage of readiness to change and covered the spectrum of his/her physical and behavioral health and psychosocial needs.

Care managers conduct care plan evaluations at varying intervals, depending on the member's individual circumstances and intensity of care management.

Recommended Interventions for 2022:

Healthy Blue MO implemented a Transitions Care Management Program to be fully dedicated to efforts involving Transition of Care, Hospital Care Transitions, and Health Home Coordination. Our fully integrated Transition Care Management Program supports transitions between settings and systems of care, including between the hospital and the community, by providing care coordination and follow-up for members after an inpatient admission. These efforts reduce inappropriate hospital readmissions by linking PCPs and specialty care providers to put the appropriate services and follow-up care in place to prevent readmission. A member of our Transitions Care Management Team outreaches the member prior to discharge when feasible, or as soon as possible following discharge to engage and work with them for an average of 14 days; connecting them with a care manager to continue management. The team provides intensive support to members to reduce 30-day readmission rates for physical health inpatient admissions and to increase 7-day and 30-day follow-up rates following a BH inpatient admission.

United Healthcare

Disease Management Program

The program focuses on populations included in the Medicaid UnitedHealthcare Community & State line of business. The scope of the Whole Person Care (WPC) Management program spans the continuum of care and includes providers, member (or caregiver) engagement and education, member self-management, and community resource linkage. WPC focuses on high-cost, complex, at-risk individuals with acute and/or chronic health care needs and, emerging risk members who need proactive management of anticipated clinical needs The WPC model can adapt and tailor to the needs of Medicaid subpopulations and other special needs populations identified by state-specific contractual requirements.

Community and State utilizes multiple data sources to identify members for care management programs. Data is analyzed at least monthly to identify members for Care Management programs.

Data sources, depending on applicability, can include, but are not limited to:

- Medical and behavioral claims or encounter data
- Pharmacy claims/Pharmacy data
- Laboratory results/data
- Health assessment results/risk assessments/scoring tool
- Electronic health records or data supplied by practitioner
- Health services with the organization/medical management programs, including data collected through the UM management process
- Data supplied by member, caregiver, discharge planner, state partner, or practitioner referral

Community and State WPC program utilizes specific criteria to identify individuals. The process of identifying members at risk is a refined, targeted approach understanding that a very small percentage of the population is responsible for a significant portion of health care spending.

The criteria for WPC include, but are not limited to:

- Specific conditions or frequent hospital or ER utilization.
- Select diagnoses with immediate plan for urgent care or ER utilization.
- High risk for readmission, complex care needs or coordination of services needed.
- Individuals identified based on calculated risk score or a percentage of population from the predictive modeling process.
- Identified catastrophic diagnosis, poses a risk of significant financial liability, or has a chronic illness requiring medically complex care.
- State contractual requirements.
- State, provider, member/caregiver and community partner referrals.

The WPC Management program consists of the following programs, which are risk-stratified into high, medium, and low acuity levels:

- High Risk Medical
- Behavioral Health
- Substance Use Disorder
- Disease Management
    - Asthma
    - Depression
    - ADHD
    - Obesity
    - Diabetes
    - Hypertension

The total number of members having each of the ICD-10 codes related to each of the disease management programs in 2022:

Program	# Identified	# Active Members	# Closed due to non-compliance with treatment plan	Participation rate
Asthma	6267	5945	12	95.0%
Hypertension	2576	2081	18	80.7%
Obesity	13117	12844	11	97.9%
Diabetes	1425	1323	9	92.8%
Depression	5930	5059	14	85.3%
ADHD	3669	3288	14	89.6%

These identified members were then further risk-stratified into low, medium, and high based on claims data and referred for intervention. Intervention frequency will differ based on risk level and assessed member acuity.

Disease management process:

- All members receive an educational mailing based on disease state. Members who are further risk stratified into High or Moderate then receive further outreach and assessment. Once the assessment is completed, additional stratification of High, Moderate or Low is based upon clinical judgement from assessment outcome. Minimum outreach requirements are dependent upon risk level.
- Focus is on providing members a primary point of contact that provides clinical complex care management with a goal of identifying/addressing barriers and gaps in care and connecting members with a primary care provider.
- Telephonic and/or field visits (field visits held until July 2022 due to COVID-19 pandemic) will be completed by a CHW, RN or BHA, and they may complete field visits as directed by their manager and/or state-specific requirements.
- Ensure the member has follow-up related to any transitions of care and understanding of medication compliance.
- Care coordination model includes interventions driven from a defined plan of care (POC) and managed by an RN or BHA clinician. If the primary care manager is a CHW, the RN or BHA will provide clinical oversight and sign off on the POC.
- Clinicians who are managing members in a High or Moderate disease management program will use professional clinical knowledge and critical thinking skills to assess the member's needs and develop the clinical POC, including interventions and referrals for specialized clinical consultation or peer support services (PSS).

- Program utilizes comprehensive assessment tools to identify the member's physical, behavioral and SDOH needs.
- Case closure is considered when the member has completed the goals of the POC, and no new goals have been identified.

Care management is a collaborative process that includes ongoing communication with the members' treating practitioners throughout active care management. Regular communication and feedback are provided to the members regarding their progress. All components of the complex care management program focus on member-centric care essential to optimizing the health status of individuals with complex and/or chronic, ongoing health care needs. If gaps in care are identified, the care manager then works with the individual and his or her provider to resolve them.

Care management is a collaborative process that includes ongoing communication with the members' treating practitioners throughout active care management. Regular communication and feedback are provided to the members regarding their progress. All components of the complex care management program focus on member-centric care essential to optimizing the health status of individuals with complex and/or chronic, ongoing health care needs. If gaps in care are identified, the care manager then works with the individual and his or her provider to resolve them.

Care managers facilitate and document in collaboration with the member or caregiver:

- A member-centric care management plan including prioritized goals that consider the member's and caregivers' goals, preferences, and desired level of involvement in the care management plan.
- Identification of interventions with timelines to meet the goals.
- Identification of barriers to meeting goals or complying with the plan.
- Development of a schedule for follow-up and communication with members. As part of the care management process, care managers assess the need for coordination of follow-up services for evaluation and management.
- Development and communication of member self-management plans.
- A process to assess progress against care management plans and adjust the care plan and its goals as needed for members.
- Locating available community resources, including vendors, to assist with member-identified and health care-related issues.
- Collaborative approaches are used for the purpose of facilitating the care management plan as well as the coordination of care. This includes all transitions of care, with the identification of risks and actions for the prevention of unplanned transitions when possible.
- Follow-up calls are scheduled to monitor compliance with the plan, and modifications are made as needed to close all remaining gaps in knowledge or care.

- Ongoing assessment is conducted at each follow-up call to identify any new problems that may have occurred or to identify any family/support issues that may need addressing to promote the member's progress.
- Co-occurring or other conditions requiring attention and management are coordinated into the plan of care.

All members receive the following information verbally upon enrollment:

- How to use the services
- How members become eligible to participate
- How to opt in or opt out

Change is challenging and leading a member through change can be even more challenging. To increase success of outreach, the state's due diligence process is completed initially and prior to closing a case for loss to contact. A new series of due diligence would start with any new triggering event.

To increase compliance throughout management, the clinician may:

- Use motivational interviewing skills
- Member input in the development of the care plan
- Educate on supporting member incentives supporting DM goals, such as completion of HRA, Adolescent Well Child Visit, and Comprehensive Diabetic Care
- Educate on value-added benefits: One Pass, YMCA, Kids Health and Asthma Support

a) Clinical Services/Clinical Practice Guidelines

UHCCP MO utilizes scientifically based clinical evidence to identify safe and effective health services for UnitedHealthcare members. The evidence-based clinical practice guidelines are sent from the National Quality Oversight Committee. Guidelines are available for diabetes, asthma, perinatal care, preventive services, attention deficit hyperactivity disorder, depression, and many other conditions. The guidelines are shared with the Quality Management Committee and adopted by the Provider Advisory Committee. Additionally, the guidelines are posted online for providers; information on how to locate the guidelines was included in the Practice Matters Newsletter. The guidelines were adopted by the Provider Advisory Committee in May 2022. Members may request a copy of the guidelines as noted in the Member Handbook posted on uhccommunityplan.com.

Criteria	Target
Care Management Assessments: Perform an assessment for care management within thirty (30) calendar days of enrollment for new members; newly diagnosed with targeted diagnosis, who have had a readmission, who have had an inpatient stay longer than 14 days, or who have 3 or more ER visits	< 30 Calendar Days w/i of Enrollment (who present with state-identified diagnosis codes/high-risk members)
Case Management: Care Plan must be updated within 90 days of inpatient stay or ER visit Document rate of compliance (%)	< 90 Days Care Plan upon inpatient stay or ER visit
Case Management: Care plan must reflect follow-up within 7 days of missed MD appointment - High-risk maternity patients with a care plan	< 7 Days Upon missed MD appointment
Case Management: Screening Children 0-6yrs must have well-child screening	
Case Management – LEAD:	Per 19 CSR 20-8.030 a child's blood lead level shall be tested with the consent of a parent or guardian when the child receives Medicaid benefits and is: •12 months of age; •24 months of age; or •Has not previously been tested for lead. Include the following services in the care plans for children with elevated blood lead levels: The health plan shall offer care management within the following timeframes to all children when knowledge of elevated blood lead levels is present (below guidelines applicable for contract requirements through October 1, 2025): • 3.5 to 9 μg/dL within five (5) business days • 10 to 19 μg/dL within one to three (1–3) business days

	• 20 to 44 μg/dL within one to two (1–2) business days • 45 to 69 μg/dL within twenty-four (24) hours • 70 μg/dL or greater – immediately Below guidelines are applicable for contract requirements after October 1, 2025: Ensure confirmation of capillary tests using venous blood according to the timeframe listed below (below guidelines applicable for contract requirements through October 1, 2025): • 3.5 to 9 μg/dL within three (3) months •10 to 44 μg/dL within one (1) month • 45 to 59 μg/dL within forty- eight (48) hours • 60 to 69 μg/dL within twenty-four (24) hours • 70 μg/dL or greater – immediately as an emergency test Below guidelines applicable for contract requirements after October 1,2025: • 3.5-9 μg/dL – Early follow-up testing – within three months, with later follow-up testing after BLL declining six to nine months; • 10-19 μg/dL – Early follow-up testing – within one to three months, with later follow-up testing after BLL declining three to six months; • 20-24 μg/dL – Early follow-up testing – within one to three months, with later follow-up testing after BLL declining in one to three months;

	• 25-44 μg/dL – Early follow-up testing within two weeks to one month, with later follow-up testing after BLL declining to one month; and • >45 μg/dL – Immediate follow-up notification of DHSS required. Early follow-up of BLL of 45-69 μg/dL requires STAT venous confirmation and receipt of result before chelation therapy is administered. • Early follow-up for BLL >70 μg/dL requires STAT venous confirmation before chelation, but chelation should commence prior to receipt of result, at the end of chelation, seven, and 21 days after chelation.
Case Management: Housing: Housing must be offered within 24 hours of being displaced Document rate of compliance (%)	< 24 Hrs. Upon being displaced
BH Case Management: Assess for case management within 5 days of admission to BH facility or Residential Substance Abuse facility	< 5 Days Assess upon admission to BH facility or Residential Substance Abuse stay or ER visit

Clinical Services manages foster care children (until July 1, 2022), members with high lead levels, Emergency room diversion, private duty nursing/personal care services, fair hearings, and high-risk maternity. The criteria for the clinical services care management programs include the following:

The Care Management Team manages several member centric programs including Healthy and High Risk Pregnancy, ER Diversion, Elevated Blood Lead Levels, Category of Aid 4 Members, Private Duty/Personal Care Services, Substance Use Disorder, Behavioral Health, Chronic Illness and Transitions of Care. Our care management model focuses on an integrated approach while maintaining one point of contact with the care management team for continuity of care.

The Care Management Team focuses on:

- Reducing Barriers to Care
- Access to Care
- Disease/Condition management and education
- Social Determinant limitations

- Referrals to community resources
- Hospitalization follow-up
- Coordination with state agencies (i.e. Children's Division, Department of Mental Health, Division of Youth Services, etc.)

Identification of members targeted for outreach for Care Management services is based on identification of Persistent Super utilizers (PSU) and Emerging Risk members based on an internally developed algorithm from claims data considering past costs drivers and anticipated future costs to determine those at highest risk and utilization of resources. Our Category of Aid 4 members are risk stratified via a system that mirrors Children's Division system (higher needs remain higher needs). This ensures consistency throughout systematic programming. The stratification may be changed based on guardian request, caregiver request or clinical need. Care Management candidates are also determined by members/caregivers requesting a PCP, member self -referral, identification by agency representatives and school nurses. Candidates are also identified based on contractual requirements as follow:

- Elevated Blood Lead Levels
- Category of Aid 4 members
- Members receiving PDN/PCS services
- ER Diversion including those members with 3+ ER visits in a quarter
- Members with a Behavioral Health Admit
- Members with a 30-day Readmission
- Members with a 14+ day Length of Stay
- Members with Special Health Care Needs
- High Risk Pregnancies
- Changes in condition

Members who are enrolled in the care management program are managed until all opportunities, goals and interventions are complete or the members opts out of continued management or no longer meets program criteria (i.e., eligibility loss). Care Management activity is monitored on an ongoing basis and outcomes are reported quarterly to the state including engagement, assessment, member contact and case closures with reason for closure. Evaluation of member participation, program effectiveness, and satisfaction with Care management (CM) is ongoing.

Strengths of the Care Management program utilized to reduce non-compliance include motivational interviewing resulting in the ability to develop rapport with our members, which assists in driving the motivation for behavioral changes. As an organization, ongoing education is provided regarding trauma informed approaches and substance use disorders as well as best practice sharing, etc. The health plan currently fits the Missouri model for a trauma responsive organization and is a trauma informed organization.

One of the main barriers encountered in providing care management services is the lack of contact information or incorrect contact information. We exhaust all due diligence attempts in searching

for member contact information, but this impedes our ability to reach our members, thus impacting the opportunity to manage. In addition to lack of adequate contact information, we run into barriers with the PCP offices unwilling to provide member information despite education on HIPAA requirements.

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.

- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: ***Tony Brite***.

c. Telephone Number: ***(573) 751-6883***

d. E-mail: ***Tony.Brite@dss.mo.gov***

e. The State is choosing to report waiver expenditures based on

_**X**_ date of payment.
___ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a. __**X**_ The State provides additional services under 1915(b)(3) authority. Effective April, 1, 2024.
b. ___ The State makes enhanced payments to contractors or providers.
c. ___ The State uses a sole-source procurement process to procure State Plan services under this waiver.
d. ___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services,*

enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a._**X**__MCO
b.___ PIHP
c.___ PAHP
d._ _ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a Fee-for-Service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a._X__Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
   1.___ First Year: $6.11____ per member per month fee (initial implementation period of 04/01/2024 - 06/30/2024)
   2.___ Second Year: $6.42___ per member per month fee (P1)
   3.___ Third Year: $6.74____ per member per month fee (P2)
   4.___ Fourth Year: $7.07___ per member per month fee (P3)
   5.____ Fifth Year: $7.43____ per member per month fee (P4)
   6.____ Sixth Year: $7.80____ per member per month fee (P5)

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. **X** Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

RESPONSE:
After the first year of the ToRCH program, ToRCH entities will be eligible for performance-based payments on the basis of achievement of goals measured during the previous year. Performance will initially be assessed and rewarded on the basis of smaller-scale goals, such as county-level population health metrics, and will transition over time to focus on reducing all-cause hospital utilization by participants living in the ToRCH counties. Reductions in the latter measure will create a source of shared savings that the state will use to calculate performance-based payments for each ToRCH entity. The approach will be to transition to payment on a shared-savings basis over time, with an increased emphasis on performance as the ToRCH program matures. Please see D.I.H.d. for a more detailed response.

d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

RESPONSE:

For the first year of the ToRCH program (April 1, 2024 – June 30, 2024) ToRCH entities will receive a PCCM community case management fee of $6.11 PMPM limited to ToRCH eligibles for coordination and analyses of SDOH needs and HRSN services utilized. This fee includes consideration for ToRCH entity staff to coordinate community services and administer the program plus the cost of providers to complete the SDOH screenings for members eligible for the ToRCH program (limited to 6 counties). The state's actuary relied upon clinical expertise, national data sources, and Missouri-Specific BLS wage data to project the PCCM community case management fee. Missouri and the state's actuary anticipate the SDOH screenings to cost $30 per screening and anticipate that approximately 75% of ToRCH eligibles will participate in screenings. Of those eligibles being screened it is anticipated that on average they will receive approximately two screenings per year. As such, a PMPM adjustment was developed for this community case management fee and incorporated in the waiver cost projections. For years two through five, the state's

actuary applied an annual trend factor, consistent with state plan trends used in D5 for waiver cost projections.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data
   1.___ Base year data is from the same population as to be included in the waiver.
   2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

_____

d. ___ [Required] Explain any other variance in eligible member months from BY to P2:

_____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS Fee-for-Service claims data:

_____

For Conversion or Renewal Waivers:

a._**X**_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b._**X**__ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

RESPONSE:

Due to the timing of the waiver, only three months of actual enrollment data is reported in R2. Actual member months are reported for the time period July 1, 2023, through September 30, 2023. The state is not including an estimate for the

remaining nine months, therefore, only 3 months of enrollment data is reported for R2.

Because the ToRCH program is being newly added to the current waiver period, historical costs for members residing in these counties are not fully reflected in R1 and R2 in tab D3 of the cost effectiveness spreadsheet. The ToRCH program covers all Medicaid eligibles in the rural ToRCH counties. Given some of these eligibles are not currently covered in the waiver, the state's actuary reviewed other historical data to incorporate all members and state plan costs for this eligible population. The Medicaid Eligibility Groups were updated to include all eligible ToRCH members and their costs.

MHD MEG:
No update needed as all eligible ToRCH members are already reflected in historical data. See the table below for ToRCH member months included for Q1 of P1.

CHIP2 MEG:
CHIP members under ME codes 73, 74, and 75 are covered in Section 1932 of the state plan and are not currently included in the 1915(b) waiver. Members with these ME codes residing in the six ToRCH counties were added to the 1915(b) waiver effective April 1, 2024. The state's actuary reviewed historical membership data for these members in the six counties from CY 2020 - CY 2022 and projected membership to SFY 2025. These additional members are included in the CHIP2 MEG in quarter 4 of P2 on D1 of the cost-effectiveness spreadsheet. See the table below for ToRCH member months included for Q1 of P1.

ToRCH AEG MEG:
The state plan amendment to add an Alternative Benefit Plan to Missouri's state plan to cover the Medicaid Expansion Population (herein referred to as the Adult Expansion Group [AEG]) was approved by CMS on December 17, 2021. This population is not authorized through the 1915(b) waiver and historically was not included in the waiver prior to the implementation of ToRCH. The AEG members residing in the six ToRCH counties were added to the 1915(b)-waiver effective April 1, 2024. The state's actuary reviewed historical membership data for members in the six counties from March 2021 – December 2022 and projected membership to SFY 2025. These additional members are included in the ToRCH AEG MEG on D1 of the cost-effectiveness spreadsheet. See the table below for ToRCH member months included for Q1 of P1.

ToRCH FFS MEG:
Medicaid members receiving services via FFS (excluded from managed care) are covered in the state plan. Historically, this population was not included in the waiver prior to the implementation of ToRCH. Members residing in the six ToRCH

counties were added to the 1915(b)-waiver effective April 1, 2024. The state's actuary reviewed historical membership data for members in the six counties from CY 2020 - CY 2022 and projected membership to SFY 2025. These additional members are included in the ToRCH AEG MEG on D1 of the cost effectiveness spreadsheet. See below table for ToRCH member months included for Q1 of P1.

MEG	Quarter 1 of P1 ToRCH Member Months
MHD	62,231
CHIP2	10,309
ToRCH AEG	33,693
ToRCH FFS	25,081

c. **X** [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

RESPONSE:

MHD and CHIP2 MEGs:
Q1 of P1 member months were updated with actual enrollment to reflect acutal disenrollment levels as a result of the continuous enrollment provision in the Families First Coronavirus Response Act (FFCRA) ending March 31, 2023. After this, the state expects member month growth to return to pre-PHE historical growth levels of approximately 0.5% quarterly. The 0.5% quarterly factor was used to project member months through P5. The member months for the new CHIP2 members added to the waiver in the ToRCH counties are trended at the same rates.

ToRCH AEG and FFS MEGs:
As a result of the addition of the new ToRCH program, the state added new member months for the ToRCH AEG and ToRCH FFS MEGs effective April 1, 2024. The state's actuary reviewed historical enrollment and discussed anticipated growth with the State to project the member months for the six ToRCH counties. Actual enrollment was updated for Q1 of P1 in D1 for this new population. Generally, enrollment for these populations is expected to increase at 0.5% per quarter, consistent with pre-pandemic enrollment trends for the historic Medicaid population.

d. **X** [Required] Explain any other variance in eligible member months from BY/R1 to P2:

RESPONSE:

The member months reported for R1 and the first 3 months of R2 is actuals. There is a gap of 9 months between R2, and P1 since CMS prefers that states do not include estimates in R2. This gap was considered when applying trend to the R2 member months to arrive at member months for the last 9 months of R2. Actual member months for all MEGs were used for Q1 of P1. See above for additional explanation on trends applied to develop P2 enrollment levels.

e. __**X**__ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

RESPONSE:

The state's R1 and R2 are on a State Fiscal Year (SFY) basis (July – June), however, R2 is only for three months.

- R1 = July 1, 2022 through June 30, 2023
- R2 = July 1, 2023 through September 30, 2023

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a._**X**__[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

RESPONSE:

The following 1915(b)(3) services were added to the waiver effective April 1, 2024 for the ToRCH program eligibles:

- Expanded Supplemental Health Related Transportation
- Nutritional counseling and education
- Home-delivered meals
- Environmental Modifications
- Environmental Goods and Services

These services are not reflected in the Actual Waiver Costs. A utilization and cost analysis were conducted for these new services. Based on this analysis, the PMPM calculated for the prior waiver amendment was added to the Total P1 PMPM 1915(b)(3) Service Cost Projections in D5 to reflect the costs of these additional services during the prior waiver period. This PMPM was then trended forward to P1 for the waiver renewal. These services are only provided to enrollees of the ToRCH program.

The PCCM community case management fee and FFS services for enrollees of the PCCM are noted in the D2.S. The projected costs for P1 are included in the Total P1 PMPM State Plan Service Cost Projections in D5 for the waiver renewal for ToRCH enrollees only.

b._**X**_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account:

RESPONSE:

No services were excluded

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-Service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the state plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

The allocation method for either initial or renewal waivers is explained below:

a._ _ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c.__X_ Other (Please explain).

RESPONSE:

MHD MEG

Effective July 1, 2021, the state began allocating administrative costs associated with MMIS activities and Medical Record reviews using a percentage based on the count of managed care claims out of total Medicaid claims. For these two categories, this approach was maintained for the current waiver renewal. Administrative costs related to the enrollment broker, EQRO and actuary are directly chargeable to managed care and do not require allocation.

CHIP2 MEG

No historical administrative costs have been reported for the CHIP2 MEG because all CHIP2 administrative costs are reported on the CMS 21, Line 33.

Additional administrative costs are noted in D5 for the ToRCH program for all MEGs. An adjustment factor was applied for the MHD MEG in D4. For the remaining MEGs, these costs were directly added to the Total P1 PMPM Administration Cost Projections in D5 since there were no prior administrative costs included in the waiver for these MEGs. Because this is a new program, no historical administrative costs are listed in D2.A. Administrative costs related to the ToRCH CIE system are directly chargeable to the ToRCH program and do not require allocation as noted in D4.

H. Appendix D3 – Actual Waiver Cost

a._X__ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be

spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

Based on timing of this renewal, the state included projections in D5 which are based on projected costs for the new 1915(b)(3) services added to the waiver effective April 1, 2024. No actual experience is available to populate D3. The below table summarizes the projected costs and PMPMs for these new services by MEG. The state's actuary relied upon clinical expertise, national data sources, discussions with the state, and Missouri utilization data, where available to project the 1915(b)(3) service expenditures. Additional considerations for member SDOH screening acceptance, and active participation or uptake of the 1915(b)(3) services were included in the projections. As such, a PMPM adjustment was developed for these services and incorporated in the waiver cost projections for each MEG in D5. The following provides more information on the specific 1915(b)(3) services being offered.

Expanded Supplemental Health Related Transportation– The cost to provide expanded supplemental health related transportation are developed using existing NEMT experience in rural Missouri, including cost per trip and users. Missouri information was also used to determine SNAP and WIC enrollment and SUD prevalence. Missouri data was supplemented with other Medicaid program data and national data as needed. The expanded supplemental health related transportation expenses reflect the cost to deliver additional trips based on expected utilization to access SNAP and WIC appointments, non-medical group therapy services, and the relevant services listed below where transportation may be needed to access those services. The unit cost and annual utilization were projected to be $50.50 per one-way trip with 21,116 one-way trips per year (or utilization/1000 of 34.0) for the period of 4/1/2024 – 6/30/2024 and were projected to P1 for the waiver renewal.

Nutritional counseling and education – The cost to provide nutritional counseling and education has been developed based on information on cost to provide similar classes in other states' Medicaid programs, state-specific information on adults accessing SNAP and WIC, information on food insecurity prevalence, and pregnancy status or relevant comorbidities among similar populations. The unit cost and annual utilization were projected to be $25.00 per nutritional counseling class and 49,449 classes per year (or utilization/1000 of 79.7) for the period of 4/1/2024 – 6/30/2024 and were projected to P1 for the waiver renewal.

Home-delivered meals - The cost to provide home delivered meals has been developed based on information on cost to provide home delivered meals in the state's 1915(c) HCBS waivers and other states' Medicaid programs, state-specific information on populations eligible and ineligible for SNAP or WIC, information on transportation insecurity and food insecurity prevalence, and pregnancy status or relevant comorbidities among similar populations. The unit cost and annual utilization were projected to be $7.87 per home delivered meal and 82,903 meals per year (or utilization/1000 of 133.6) for the period of 4/1/2024 – 6/30/2024 and were projected to P1 for the waiver renewal. Note that cost may be slightly lower if some meals are picked up, which will be at the participant's discretion if more convenient and timely for them, but this is not expected to represent a large share of the activity and has therefore not been explicitly factored in to the cost estimates.

Environmental Modifications including Goods and Services - The cost to provide home modifications to address safety hazards and breathing related conditions has been developed based on information on cost to provide similar services through the state's HCBS 1915(c) waivers and national average costs for repairs to address safety and breathing related conditions, information on housing insecurity prevalence, aging or SSI-status of members in Missouri Medicaid, and relevant comorbidities such as Asthma and COPD. The unit cost and annual utilization for Home Modifications to address Safety were projected to be $4,080 per home modification and 473 home modifications per year (or utilization/1000 of 0.8). The unit cost and annual utilization for Home Modifications to address Air Quality and Breathing were projected to be $1,516 per home modification and 833 home modifications per year (or utilization/1000 of 1.3). These assumptions

were developed for the period of 4/1/2024 – 6/30/2023 and were projected to P1 for the waiver renewal.

The state relied on the 1915(b)(3) projections used in the waiver amendment sent on December 26, 2023. The Total Waiver MMs shown in the table below are the Projected Year 2 Member Months from the prior waiver amendment, and the Total 1915(b)(3) PMPMs by MEG are consistent with the Total P2 PMPM 1915(b)(3) Service Cost Projection included in D5 of the prior waiver amendment. The 1915(b)(3) services projection for Environmental Modification and Goods and Services reflects expected cost projections for both the Environmental Modification and Environmental Goods and Services 1915(b)(3) services.

The following table provides the expected costs of the 1915(b)(3) services for the ToRCH population during the effective waiver period of April 1, 2024 – June 30, 2024.

1915(b)(3) Services Projection from Prior Waiver Amendment (ToRCH implementation)

1915(b)(3) Service	**MHD MEG**	**CHIP2 MEG**	**ToRCH AEG MEG**	**ToRCH FFS MEG**	**Total**
Expanded Supplemental Health Related Transportation	$178,575	$1,190	$31,150	$40,925	$251,841
Nutritional counseling and education	$202,432	$3,438	$37,286	$48,992	$292,149
Home-delivered meals	$93,625	$15,915	$37,136	$7,037	$153,714
Environmental Modifications and Goods and Services	$123,572	$15,462	$171,873	$477,172	$788,079
Total 1915(b)(3) Dollars	$598,205	$36,006	$277,445	$574,127	$1,485,783
Total Waiver MMs	8,020,768	572,781	35,457	35,902	8,664,908
Total 1915(b)(3) PMPM	**$0.07**	**$0.06**	**$7.84**	**$16.00**	**$0.17**

The state then projected these 1915(b)(3) service costs for P1 – P5 of the waiver renewal as outlined in Section D4. Note that given the ToRCH program will be effective during the entire P1 year for all MEGs, the MHD and CHIP2 MEG PMPMs also reflect an adjustment to account for one year of member months. This is compared to the single quarter included on the prior

amendment which increased the ToRCH PMPM by about 330% for both the MHD and CHIP2 MEGs. Total PMPM is calculated by weighted MEG PMPMs on corresponding projected P1 member months for SFY 2025.

1915(b)(3) Service	MHD MEG	CHIP2 MEG	ToRCH AEG MEG	ToRCH FFS MEG	Total
Total 1915(b)(3) PMPM – P1	**$0.34**	**$0.28**	**$8.23**	**$17.12**	**$0.74**

The anticipated waiver savings utilized to fund the new 1915(b)(3) services for the waiver period of April 1, 2024, through June 30, 2024 are summarized in the below table. These savings are projected based on the managed care delivery system and preventive care and cost containment strategies that focus on avoidable inpatient hospitalizations. Savings shown below are savings in inpatient hospital costs to the waiver program for the projected time period of April – June 2024.

The Total Waiver MMs shown in the table below are the Projected Year 2 Member Months from the prior waiver amendment. By using the Total P2 Member Months the Total 1915(b) Savings PMPM are lower than the expected monthly savings but reflect the savings impact to P2 from the prior waiver amendment.

The basis of these avoidable inpatient hospitalizations and associated savings projections is actual state managed care experience, clinical expertise, and national data sources. In review of the state managed care experience, the state's actuary identified inpatient admissions that could have been avoided through high quality outpatient care and/or reflects conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately. This analysis resulted in savings of 1.47% of inpatient hospital costs or 0.45% of medical costs and were applied to the managed care component of the waiver state plan services costs during the effective period of ToRCH in the waiver. These anticipated costs were applied to the managed care MEGs (MHD, CHIP2, and ToRCH AEG). Only 20% of these savings were assumed for the ToRCH FFS population due to the more limited care management delivery model of the ToRCH community PCCM as compared to the savings from a full risk managed care model present in the other MEGs. As the savings are intended to be projected savings during the time period starting with the effective date of the ToRCH program, savings were projected for populations included in the waiver amendment for April 1, 2024 – June 30, 2024.

The savings included for the FFS population is attributable to savings expected through the community PCCM delivery model services (i.e. coordination of health-related social needs and physical health needs) provided in the ToRCH model, which was informed by actual hospital savings experience from the full-risk managed care population. The state expects that the community PCCM model will result in savings to hospital experience for the current FFS

population by addressing social needs, but not to the degree or intensity of the full-risk managed care population. Therefore, the state and the state's actuary took a more conservative approach to estimating savings from state plan services for this population.

1915(b) Savings	MHD MEG	CHIP2 MEG	ToRCH AEG MEG	ToRCH FFS MEG	Total
Total 1915(b) Savings	$4,069,276	$147,210	$79,810	$64,421	$4,360,716
Total Waiver MMs	8,020,768	572,781	35,457	35,902	8,664,908
Total 1915(b) Savings PMPM	**$0.51**	**$0.26**	**$2.25**	**$1.79**	**$0.50**

These savings assumptions are not reflective of the total savings anticipated from the full-risk managed care or the ToRCH community PCCM program, but are a conservative assumption of the portion of the potential savings attributable to avoidable inpatient hospitalizations. The savings in total of $0.50 PMPM are more than sufficient waiver savings to fund the 1915(b)(3) ToRCH program anticipated services of $0.17 PMPM during the waiver period from April 1, 2024, through June 30, 2024.

The savings assumptions outlined above from the prior Waiver Amendment (ToRCH Implementation) will continue within the waiver renewal effective July 2025. In order to ensure (b)(3) spending will not be more than the savings assumed, (b)(3) spending will not trend higher than other state plan services.

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c._**X** Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the

effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:
1. **X** The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d. **X** Incentive/bonus/enhanced Payments for both Capitated and Fee-for-Service Programs:

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.
   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses, and
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2. **X** For the Fee-for-Service portion of the waiver, all Fee-for-Service must be accounted for in the Fee-for-Service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for Fee-for-Service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**
   i. Document the criteria for awarding the incentive payments.

   RESPONSE: After the first year of the ToRCH program, ToRCH entities will be eligible for performance-based payments on the basis of achievement of goals measured during the previous year. Performance will initially be assessed and rewarded on the basis of goals for five county-level population health metrics (e.g., selected HEDIS measures, WIC uptake rates, etc., for which the state has a validated numerator and denominator available at the county level). ToRCH hubs must meet or exceed the target rate to earn those incentives. Over time, shared savings components will be

phased in based on reducing all-cause hospital utilization by participants living in the ToRCH counties. The shared savings payments will be earned when total size of the hub's activities under the waiver are less than the total estimated hospital utilization that the state estimates would have occurred, absent the model.

ii. Document the method for calculating incentives/bonuses, and

RESPONSE: The state will analyze total hospital spending in all rural Missouri counties, and predicted ToRCH county spending in the absence of ToRCH will be estimated through multivariate modeling that corrects for differences in the demographic composition of the population. These predicted values will be compared to actual hospital spending in each ToRCH county in each performance year, and the difference will be considered the total savings produced by the model. This value will be compared to the total size of the hub's activities under the waiver (administration, screenings, and b3 services), and when the former exceeds the latter, the ToRCH hub will earn a minimum of 60% and a maximum of 75% of the difference (depending on population health goal success).

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

RESPONSE: The method explained above ensures that the incentive payments will not exceed 75% of the spending that otherwise would have occurred for state plan hospital services, similar to the documentation provided in the Waiver Cost Projection. While the model may drive more utilization of primary care state plan services, these increases are anticipated to be fairly small. The total spend will be monitored on a quarterly basis.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not

duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment.

Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.
E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for Fee-for-Service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the Fee-for-Service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____Other (please describe)

ii.___ FFS cost increases were accounted for.
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

***** For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end

of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present)*. The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from Fee-for-Service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:
1.___ No adjustment was necessary
2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
    i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
    ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the Fee-for-Service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:
1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over-the-counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population which includes accounting for Part D dual eligibles. Please account for this adjustment in **Appendix D5**.
2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS or Part D for the dual eligibles.
3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from base year data.
2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2.___ This adjustment was made:
a. ___Potential Selection bias was measured in the following manner:
b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect Fee-for-Service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3.___ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:
The State is implementing the first year of a new capitated program (converting from Fee-for-Service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:
Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations

-- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

Adjustment	Capitated Program	PCCM Program
	Calculations -- See the next column)	

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When Fee-for-Service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported. Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments. If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. **X** [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present).* The actual trend rate used is: _

- MHD and CHIP2 MEGs = 6.94% P1 and 5.00% P2 through P5
- ToRCH AEG MEG = 3.1% P1 and 5.00% P2 through P5
- ToRCH FFS MEG = 2.6% P1 and 7.00% P2 through P5

Please document how that trend was calculated:

RESPONSE:

The P1 through P5 trend rates were developed independently from any impact for programmatic changes. P1 costs are projected from the three months of data for R2. The following represents the impacts for the P1 and P2 time period:

MHD and CHIP2 MEGs:

- Since there is a nine month gap between R2 and P1, the trend in P1 covers 16.5 months, not 12 months for the MHD and CHIP2 MEGs: (6.94% = (1 + 5.00%)^(16.5/12) – 1)

- To develop P2 – P5 costs, the prior projection year values were trended an additional 12 months, each year utilizing a 5.00% annual trend factor.

ToRCH AEG MEG:

- The trend in P1 covers 7.5 months, not 12 months for the MEG: (3.10% = (1 + 5.00%)^(7.5/12) – 1).
- To develop P2 – P5 costs, the prior projection year values were trended an additional 12 months, each year utilizing a 5.00% annual trend factor.

ToRCH FFS MEG:

- The trend in P1 covers 4.5 months, not 12 months for the MEG: (2.6% = (1 + 7.00%)^(4.5/12) – 1).
  To develop P2 – P5 costs, the prior projection year values were trended an additional 12 months, each year utilizing a 7.00% annual trend factor.

See response below (J. Appendix D4 – a.2) for specifics regarding development of the annual trend factor.

2. **X** [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. **X** State historical cost increases. Please indicate the years on which the rates are based: base years 2020, 2021, 2022, and 2023. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

RESPONSE:

Trend rates were developed independently from any impact for programmatic changes and were developed on a PMPM basis, including consideration for unit cost and utilization changes. Trends for the capitated services are consistent with those used in rate development.

In developing the trend assumptions, Mercer reviewed and utilized multiple sources of data and information including:

- Historic data specific to the Missouri Medicaid Managed Care Program (encounter data and health plan-reported financial data)
- Health plan-specific trend estimates provided by the plan actuaries
- CMS reported information specific to non-capitated costs
- Historical data specific to the Missouri Medicaid FFS program

No one, or combination of, data and information source(s), is utilized within a prescribed formula. Note that the trend assumptions used for rate development were further summarized across all managed care regions and rate cells to arrive at the annual trend factor used for waiver projections.

ii. **X** National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used CPI, DRI, and regional Medicaid experience from other programs. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

RESPONSE:

Trends are based primarily on the state's experience; however, the development of trend rates is supplemented by national and regional indicators for broad categories of service including Inpatient, Outpatient, Physician Services, and Other.

Managed care trends were reviewed by category of service, and population, for the MO HealthNet Managed Care program and for other state Medicaid programs when developing trend for the MO HealthNet Managed Care program. Based on this information, national indices, and utilization and cost trends experienced in the MO HealthNet Managed Care and FFS programs, annualized trends of 5.00% for the MHD, CHIP2, and ToRCH AEG all MEGs were used to project P1 through P5. Annualized trends of 7.00% for the ToRCH FFS MEG were used to project P1 through P5.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __X__ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2._**X**__An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment ____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Determine adjustment for Medicare Part D dual eligibles.
E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.___ Changes in legislation (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi._**X**_ Other (please describe):

A. _**_**_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. _**_**The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment ___

RESPONSE:

C. ____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D._**X**_ Other (please describe):

RESPONSE:

ToRCH PCCM Community Case Management Fee Adjustment

ToRCH entities will receive a PCCM community case management fee of $6.42 PMPM limited to ToRCH eligibles for coordination and analyses of SDOH needs and HRSN services utilized for SFY 2025. This fee includes consideration for ToRCH entity staff to coordinate community services and administer the program plus the cost of providers to complete the SDOH screenings for members eligible for the ToRCH program (limited to 6 counties). As this fee is only applicable to members residing in the ToRCH counties, the state's actuary applied only the portion of the fee applicable to the ToRCH members for the MHD and CHIP2 MEGs. Based on timing of this

programmatic change, the state included projections in D5 inclusive of the PCCM community case management fee for the ToRCH AEG and FFS MEGs versus updating D4.

PMPM impact built into the waiver projections:

MHD MEG: $0.23 for P1
CHIP2 MEG: $0.51 for P1

ToRCH CHIP2 Acuity Adjustment

CHIP members under ME codes 73, 74, and 75 are covered in Section 1932 of the state plan. Members in these ME codes residing in the six ToRCH counties were added to the 1915(b)-waiver effective April 1, 2024. The state's actuary reviewed historical claims data for these members in the six counties from CY 2020 - CY 2022, projected costs to SFY 2025, and compared projected costs to current members covered in the 1915(b) waiver. As such, an adjustment was developed to account for differences in historical costs between the two populations and applied to the waiver cost projections.

PMPM impact built into the waiver projections:

MHD MEG: $0.00 for P1
CHIP2 MEG: $5.35 for P1

PHE Enrollment Acuity Adjustment

With the termination of the continuous enrollment provision of the FFCRA on March 31, 2023, the state's actuary assumed there would be an increase in the population acuity for the population that maintained coverage. As such, an adjustment was estimated for the capitation rates, and this estimate was leveraged for purposes of applying to the waiver cost projections. While the ToRCH FFS MEG was not included in the capitation rates for calculation of the adjustment, a similar adjustment was applied to the MEG for purposes of waiver projections as it is assumed that there will be a similar impact to the FFS population as there is in managed care.

PMPM impact built into the waiver projections:

MHD MEG: $33.40 for P1
CHIP2 MEG: $10.64 for P1
ToRCH AEG: $169.60 for P1

ToRCH FFS: $300.67 for P1

c. X Administrative Cost Adjustment: This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2. **X** An administrative adjustment was made.
   i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
   ii.___ Cost increases were accounted for.
      A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
      B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
      C. **X** State Historical State Administrative Inflation. The actual trend rate used is: 31.4% annual trend for P1 and 4.0% for P2 through P5. Please document how that trend was calculated:

RESPONSE:

MHD MEG

R2 includes costs for only three months which reflects actual administrative expenditures paid July 1, 2023 through September 30, 2023. Administrative expenditures were projected from R2 considering both the lag in historical administrative payments in the first half of a fiscal year and the last half of a fiscal year, as well as ongoing historical increases in administrative expenses. Based on these factors, the administrative PMPM in R2 increased from the $1.82 PMPM reported for the first three months to $2.19 PMPM for the entire 12 months of SFY 2025 (P1), or an increase of 20.2%.

The state will contract with UniteUs to develop an electronic health records technology system, Community Information Exchange (CIE), to coordinate, monitor, and conduct analyses of the services

provided through a closed-loop referral system specifically for the ToRCH program. The cost for this system is not reflected in the historical administrative costs. As such an adjustment was developed to allocate the portion of the total CIE cost to the MHD MEG ToRCH eligibles and the administrative PMPM increased by $0.20 from $2.19 to $2.39 or an adjustment of 9.3% in P1.

The total projected P1 administrative PMPM is $2.39.

CHIP2 MEG

No historical administrative costs have been reported for the CHIP2 MEG because all CHIP2 administrative costs are reported under the 1115 Waiver on the CMS 21, Line 33.

D.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2._**X**__[Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates
   1. Please indicate the years on which the rates are based: base years_N/A – newly added services._____
   2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend
   1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above ___5% for the MHD, CHIP2, and ToRCH AEG MEGs. 7% for the ToRCH FFS MEG.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _5 or 7% based on MEG_____
2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _5 or 7%_____
3. Explain any differences: Incentives will be trended at the same rate as state plan services as the amounts paid in incentives are based on overall savings and expected to grow at similar rates to other service trends.

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the

supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population which includes accounting for Part D dual eligibles. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS or Part D for the dual eligibles.

3. ____Other (please describe):

1.___**X**_ No adjustment was made.

RESPONSE:

No adjustment was necessary for the pharmacy rebate factor as the FFS pharmacy costs reported in the base period were net of rebates.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

RESPONSE:

Based on timing of this renewal, the state included projections in D5 to account for the projected cost of the new ToRCH program effective April 1, 2024.

CHIP2 MEG:
The state will contract with UniteUs to develop an electronic health records technology system, Community Information Exchange (CIE), to coordinate, monitor, and conduct analyses of the services provided through a closed-loop referral system specifically for the ToRCH program. The cost for this system is not reflected in the historical administrative costs. As such, a $0.20 PMPM was developed to allocate the portion of the total CIE cost to the CHIP2 MEG ToRCH eligibles.

ToRCH AEG MEG:
The AEG members residing in the six ToRCH counties were added to the 1915(b) waiver effective April 1, 2024. The state's actuary relied on the resulting $1,027.40 P2 projected PMPM from the prior waiver amendment as the starting point for the R2 PMPM for the waiver renewal. To project the $1,027.40 PMPM to P1, an additional annualized trend factor of 5.0% was used to project the PMPM 7.5 months to P1 of the waiver renewal. Overall, this resulted in a total P1 PMPM of $1,059.21.

The state will be contracting with UniteUs to develop an electronic health records technology system, Community Information Exchange (CIE), to coordinate, monitor, and conduct analyses of the services provided through a closed-loop referral system specifically for the ToRCH program. The cost for this system is not reflected in the historical administrative costs. As such, a $0.20 PMPM was developed to allocate the portion of the total CIE cost to the ToRCH AEG MEG ToRCH eligibles.

ToRCH FFS MEG:
Members residing in the six ToRCH counties were added to the 1915(b) waiver effective April 1, 2024. The state's actuary and the state reviewed emerging Q1 data for P1 and identified an error in the base data used to develop the ToRCH FFS MEG. The state is working to make prior-quarter adjustments and will be updating CMS-64 reporting for Q1 of P1. The state's actuary relied on the actual data from Q1 of P1 or a $3,699.22 PMPM as the starting point for the R2 PMPM for the waiver amendment. To project the $3,699.22 PMPM to P1, an additional annualized trend factor of 7.0% was used to project the PMPM 4.5 months to P1 of the waiver amendment. Overall, this resulted in a state plan inflation adjusted P1 PMPM of $3,794.28. Please see above for additional program adjustments included to get to the resulting total P1 PMPM.

The state will contract with UniteUs to develop an electronic health records technology system, Community Information Exchange (CIE), to coordinate, monitor, and conduct analyses of the services provided through a closed-loop referral system specifically for the ToRCH program. The cost for this system is not reflected in the historical administrative costs. As such, a $0.20 PMPM was developed to allocate the portion of the total CIE cost to the ToRCH FFS MEG ToRCH eligibles.

PMPM Casemix for R2 (R2 MMs):
In order to reflect the impact of the new membership and additional cost to implement ToRCH, the formulas to calculate the P1 through P5 PMPM Casemix for R2 (R2 MMs) have been revised to weight the average PMPM impact based on the corresponding projected enrollment casemix for P1 through P5 as opposed to the R2 membership. This change is needed to recognize the relative impact to the Total PMPM costs, based on the total membership under the 1915(b) waiver with the inclusion of ToRCH.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 – Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

RESPONSE:

The member months reported for R1 and the first 3 months of R2 are actuals. There is a gap of 9 months between R2 and P1 since CMS prefers that states do not include estimates in R2. This gap was considered when applying trend to the R2 member months to arrive at member months for the last 9 months of R2.

MHD and CHIP2 MEGs:
Q1 of P1 member months were updated with actual enrollment to reflect actual disenrollment levels as a results of the continuous enrollment provision in the Families First Coronavirus Response Act (FFCRA) ending March 31, 2023. After

this, the state expects member months growth to return to pre-PHE historical growth levels of approximately 0.5% quarterly. The 0.5% quarterly factor was used to project member months through P5. The member months for the new CHIP2 members added to the waiver in the ToRCH counties are trended at the same rate.

ToRCH AEG and FFS MEGs:
As a result of the addition of the new ToRCH program, the state added new member months for the ToRCH AEG and ToRCH FFS MEGs effective April 1, 2024. The state's actuary reviewed historical enrollment and discussed anticipated growth with the state to project the member months for P1 through P5 for the six ToRCH counties. Actual enrollment was updated for Q1 of P1 in D1 for this new population. Generally, enrollment for these populations are expected to increase at 0.5% per quarter, consistent with pre-pandemic enrollment trends for the historic Medicaid population.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

RESPONSE for M.a.2 and M.a.3:

Trend
Trend rates were developed independent from any impact for programmatic changes and were developed on a PMPM basis, including consideration for unit cost and utilization changes. Trends for the capitated services are consistent with those used in rate development.

In developing the trend assumptions, Mercer reviewed and utilized multiple sources of data and information including:

- Historic data specific to the Missouri Medicaid Managed Care Program (encounter data and health plan-reported financial data)
- Health plan-specific trend estimates provided by the plan actuaries
- CMS reported information specific to non-capitated costs
- Historical data specific to the Missouri Medicaid FFS program

No one, or combination of, data and information source(s), is utilized within a prescribed formula. Note that the trend assumptions used for rate development were further summarized across all managed care regions and rate cells to arrive at the annual trend factor used for waiver projections.

Trends are based primarily on the state's experience; however, the development of trend rates is supplemented by national and regional indicators for broad categories of service including Inpatient, Outpatient, Physician Services, and Other.

Managed care trends were reviewed by category of service, and population, for the MO HealthNet Managed Care program and for other state Medicaid programs when developing trend for the MO HealthNet Managed Care program. Based on this information, national indices, and utilization and cost trends experienced in the MO HealthNet Managed Care and FFS programs, an annualized trend of 5.0% was used to project the R2 waiver cost to P1. P5 for the MHD, CHIP2, and ToRCH AEG MEGs. An annualized trend of 7.0% was used to project the R2 waiver cost to P1 for the ToRCH FFS MEG.

Programmatic Changes

Please refer to section J.b (Appendix D4 – State Plan Services Programmatic / Policy / Pricing Change Adjustment) of the waiver narrative (above) for specifics regarding descriptions of the programmatic changes incorporated into the waiver projections. Please see below for a list of all adjustments along with the PMPM impacts.

	MHD MEG	CHIP 2 MEG	ToRCH AEG	ToRCH FFS
	P1 PMPM Impact	P1 PMPM Impact	P1 PMPM Impact	P1 PMPM Impact
PCCM Community Case Management Fee Adjustment	$0.23	$0.51	N/A	N/A
ToRCH CHIP2 Acuity Adjustment	$0.00	$5.35	N/A	N/A
PHE Enrollment Acuity Adjustmnet	$33.40	$10.64	$169.60	$300.67
Net Impact	**$33.63**	**$16.50**	**$169.60**	**$300.67**
Percent Impact	**8.0%**	**6.2%**	**16.0%**	**7.9%**

Incentive Payments:

Additional payments made in P2 on the basis of performance on population health goals for ToRCH MEGs were included as a programmatic change and are based on the methodology describe in H.d and trended using the same trend as other state plan services in each MEG.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

Glossary

ACA – Affordable Care Act

ACD – Automatic Call Distribution

AIDS - Auto Immune Deficiency Syndrome

AFDC- Aid to Families with Dependent Children

AFH – Advocates for Family Health

ARCHS - Area Resources for Community and Human Services

ASA - Average Speed of Answer

BCCT - Breast and Cervical Cancer Treatment

BHC - Behavioral Health Concepts

BMO - Benefit Management Organization

CAC - Consumer Advisory Committee

CAHPS - Consumer Assessment Health Plan Survey

CMHC HCH – Community Mental Health Center Healthcare Home

CMS - Centers for Medicare and Medicaid Services

COC – Cornerstones of Care

CPS – Comprehensive Psychiatric Services

CSHCN - Children with Special Health Care Needs

CSMT – Comprehensive System Management Team

CSO – Customer Service Organization

C-STAR - Comprehensive Substance Treatment Abuse and Rehabilitation

CY - Calendar Year

DCI – Department of Commerce and Insurance

DD - Developmentally Disabled

DESE - Department of Elementary and Secondary Education

DHSS - Department of Health and Senior Services

DM – Disease Management

DMH - Department of Mental Health

DYS – Division of Youth Services

ECCS – Early Childhood Comprehensive System

EHR – Electronic Health Record

EPSDT - Early Periodic Screening, Diagnosis, and Treatment

EQRO - External Quality Review Organization

FFS – Fee-for-Service

FSD – Family Support Division

FQHC - Federally Qualified Health Centers

HB - House Bill

HCUSA - HealthCare USA

HEDIS - Health Employer and Data Information Set

HIPAA - Health Insurance Portability and Accountability Act

HIT – Health information Technology

HSHP – Home State Health Plan

IEP - Individualized Education Plan

ISCA – Information System Capabilities Assessment

JCAHO - Joint Commission for Accreditation of Health CareLBW - Low Birth Weight

LINC - Local Investment Commission

MAC – MO HealthNet Member Advisory Committee or Member Forum

MBHOs – Managed Behavioral Health Organizations

MCHP – Managed Care Health Plan

MCO - Managed Care Organization

MHD – MO HealthNet Division

MHF – MO HealthNet for Families

MHK – MO HealthNet for Kids

MO Care – Missouri Care now known as Healthy Blue

NCM – Nurse Case Management

NCQA - National Committee for Quality Assurance

NEMT - Non-Emergency Medical Transportation

OPI – Opioid Prescription Intervention

PA - Prior Authorization

PCHH – Primary Care Health Home

PCP - Primary Care Provider

PIP – Performance Improvement Project

PMPM - Per Member Per Month

QA&I - Quality Assessment and Improvement

RAE – Risk-Adjusted Efficiency

RAR – Risk-Adjusted Rates

RFP - Request for Proposal

RHC - Rural Health Clinic

SAC – Statewide Advisory Council

SAG – Stakeholders Advisory Group

SFY - State Fiscal Year

SHCN - Special Health Care Needs

SMBF – Show Me Bright Futures

SOC – System of Care

SOC WG – System of Care Work Group

SPA – State Plan Amendment

SSI - Supplemental Security Income

TANF - Temporary Assistance for Needy Families

UM - Utilization Management

UPL - Upper Payment Limit

VBAC – Vaginal Birth After Caesarian

WIC - Women, Infants, and Children

WY - Waiver Year