Table of Contents

State/Territory Name: MO

State Plan Amendment (SPA) #: 21-0037

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 20, 2021

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

Re: Missouri State Plan Amendment (SPA) 21-0037

Dear Mr. Richardson:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (MO) 21-0037. This amendment proposes to provide authority to enroll the new Adult Expansion Group (AEG) into managed care and to provide services through the managed care program.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR § 435.733. This letter is to inform you that Missouri Medicaid SPA 21-0037 was approved on December 17, 2021, with an effective date of October 1, 2021.

If you have any questions, please contact Kia Carter-Anderson at 404-562-7431 or via email at kia.carter-anderson@cms.hhs.gov.

Sincerely,

Bill Brooks, Director
Division of Managed Care Operations

cc: Kathryn Dinwiddie
Tameka Whitney

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0037

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☒ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Public Law 111-148 (ACA); 42 CFR 433; 1905(y)(1) of the Social Security Act; 1932(a) Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 21 $ 1,186,671,000
b. FFY 22 $ 1,582,226,120

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-F, pages 1-23

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
New

10. SUBJECT OF AMENDMENT
The purpose of this State Plan is to provide authority to enroll the new Adult Expansion Group (AEG) into Managed Care and to provide services through the Managed Care Program.

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: Robert J. Knowles

14. TITLE: Acting Dept. Director

15. DATE SUBMITTED: [redacted] 9/21/2021

16. RETURN TO
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 21, 2021

18. DATE APPROVED: December 17, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: Bill D. Brooks

22. TITLE: Director, Division of Managed Care Operations

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

State:

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Missouri enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs],and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒ MCO
   a. ☒ Capitation
   b. ☒ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. ☐ Other (please explain below)

State:

Citation	Condition or Requirement
	If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services: ☐ Provision of intensive telephonic case management ☐ Provision of face-to-face case management ☐ Operation of a nurse triage advice line ☐ Development of enrollee care plans. ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program ☐ Oversight responsibilities for the activities of FFS providers in the FFS program ☐ Provision of payments to FFS providers on behalf of the State. ☐ Provision of enrollee outreach and education activities. ☐ Operation of a customer service call center. ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement. ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers. ☐ Coordination with behavioral health systems/providers. ☐ Coordination with long-term services and supports systems/providers. ☐ Other (please describe): _____
42 CFR 438.50(b)(4)	C. Public Process. Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)* If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110) Response: Missouri's MO HealthNet Managed Care program has been in existence since 1995, and has been statewide for pregnant women, children and custodial adults since 2017. The State believes that one of the keys to a successful program include the involvement and input of stakeholders to inform health care policy and service delivery. Examples of forums, workgroups, meetings and other means of engaging our stakeholder partners are:

- The Member Forum which is inclusive of participants in both the managed care and fee-for-service programs.
- Periodic meetings with Cover Missouri, a group working to assist Missourians in obtaining health insurance.
- Frequent meetings and interactions with 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 provider groups such as the Missouri Primary Care Association, Missouri Dental Association, 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.
- 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.
- State webpage with information for participants, contracted health plans, providers, and, the public.
- Public hearings and comment periods for public input when policy is changed or new policy is created.
- Publication of provider bulletins on the State website and the opportunity for anyone to receive program updates through email blasts.

The State's expansion of Medicaid to the Adult Expansion Group (AEG) is the result of a voter ballot initiative amending the State Constitution. Public interest groups worked together for over two years to place the initiative on the ballot in August 2020. Since that time, the State used a "Team of Teams" approach to coordinate all state entities necessary to make decisions and operationalize the implementation of the program.

Missouri does not have federally recognized Native American tribes therefore, tribal consultations were not held. Missouri does not offer Long Term Services

State:

and Supports (LTSS) in the Managed Care Program.

D. State Assurances and Compliance with the Statute and Regulations.
If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)

1. ☒ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

State:

Citation		Condition or Requirement
42 CFR 438.50(c)(1)		
1932(a)(1)(A)(i)(I) 1905(t)	2.	☐ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.
42 CFR 438.50(c)(2) 1902(a)(23)(A)		
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	☒ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	4.	☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5.	☒ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6.	☒ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7.	☒ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8.	☐ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9.	☒ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10.	Assurances regarding state monitoring requirements:

State:

Citation	Condition or Requirement

☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.
☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.
☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area.

1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110					
2. Pregnant Women	§435.116					
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118					
4. Former Foster Care Youth (up to age 26)	§435.150					
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	☒			Statewide	
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA					
7. Extended Medicaid Due to Spousal Support Collections	§435.115					

State:

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120					
9. Aged and Disabled Individuals in 209(b) States	§435.121					
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135					
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137					
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138					
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA					
14. Disabled Adult Children	1634(c) of SSA					

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					
2. Optional Targeted Low-Income Children	§435.229					
3. Independent Foster Care Adolescents Under Age 21	§435.226					
4. Individuals Under Age 65 with Income Over 133%	§435.218					
5. Optional Reasonable Classifications of Children Under Age 21	§435.222					
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					

State:

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230					
8. Individuals eligible for Cash except for Institutionalized Status	§435.211					
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217					
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236					
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA					
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA					
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA					
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA					
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA					
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					

State:

Citation | Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214					
22. Individuals with Tuberculosis	§435.215					
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213					

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)					
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)					
3. Medically Needy Children Age 18 through 20	§435.308					
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					
5. Medically Needy Aged	§435.320					
6. Medically Needy Blind	§435.322					
7. Medically Needy Disabled	§435.324					
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA				

State:

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare					
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14				
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120				
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA				
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145				
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227				
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.					

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

State:

Citation | Condition or Requirement

Population	V	E	Notes
Other Insurance–Medicaid beneficiaries who have other health insurance			
Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).			
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			
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).			
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.			
Other (Please define):			

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specicifed in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

      State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.
      i. Please indicate the length of the enrollment choice period: _____

State:

Citation	Condition or Requirement

c. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.
   i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).
   ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system: _____

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

   Response: The state uses an enrollment broker that provides each potential enrollee an enrollment packet that contains an informational brochure on the MO HealthNet Managed Care Program including its benefits and use, the MCOs available, and information on how to access the PCP listing. 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 and potential enrollees who call the MO HealthNet Managed Care Enrollment Helpline on the MO HealthNet Managed Care Program benefits and use.

   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. The enrollment broker, through the enrollment packet, notifies all potential 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 has three 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.

b. ☒ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.
    i. Please indicate the length of the enrollment choice period:

Response: The State auto-assigns enrollees into a health plan on the day they are found eligible for MO HealthNet. The algorithm is described below. If an enrollee wishes to change their health plan, they may do so within 90 days for any reason, then at any time for just cause reasons.

c. ☒ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
    i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

Response: The auto-assignment algorithm assigns enrollees as follows:

a) If the MO HealthNet Managed Care enrollee is enrolled with a MCO, the MO HealthNet Managed Care enrollee shall be assigned to that MCO. 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 a 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 a 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:

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.

d. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

1932(a)(4)
42 CFR 438.54

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

a.☒ The state assures that, per the choice requirements in 42 CFR 438.52:

Citation / Condition or Requirement	
	i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of a least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
	ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
	iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

b. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

☒ This provision is not applicable to this 1932 State Plan Amendment.

c. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐ This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.71

d. ☒ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will ☒ / will not ☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for 12 months (up to 12 months).

3. ☒ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*

Response: Beneficiaries are informed of their right to disenroll without cause through the services provided by the enrollment broker; in enrollment materials published on the state's website and in the enrollment packet; and, in the member handbook provided by the beneficiary's health plan.

5. Describe any additional circumstances of "cause" for disenrollment (if any).
   - 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.
- Information on the PCP listing was incorrect. The MCO chosen by the enrollee was based on the information given on the listing.
- A special health care needs enrollee (Title V, SSI and foster care) requests a different MCO with the approval of the State.
- Children in State custody or foster care placement are allowed automatic and unlimited changes in MCO. They may change MCOs as often as their foster care placement changes necessitate. Foster parents normally have the decision-making responsibility for choosing which MCO will serve the foster child residing with them. However, there will be situations where the social service worker or the courts will select the MCO for the child in State custody or foster care placement.
- Any adoption subsidy individual may choose not to enroll or voluntarily disenroll at any time.
- Any individual receiving SSI or who meets the medical definition for SSI benefits may choose not to enroll or 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 transfer in order for all family members to be enrolled with the same health plan.

State:

Citation	Condition or Requirement

H. Information Requirements for Beneficiaries.

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Ex. Physical Therapy	*3.1-A*	*4*	*11.a*
Ambulatory Patient Services o Outpatient Hospital Services o Family Planning Services o Physician Services o Podiatrist Services o Nurse Practitioners/Clinical Nurse Specialist o Physician Assistant o Assistant Physician o Chiropractor o Anesthesiologist Assistant o Clinic Services o Dental Services o Hospice o Non-Emergency Medical Transportation (NEMT)	ABP5 AEG	2-6	1

State:

Emergency Services o Emergency Medical Technicians o Paramedics o Transportation o Outpatient Hospital Services	ABP5 AEG	7-8	2
Hospitalization o Inpatient Hospital o Physician Services	ABP5 AEG	9	3
Maternity and Newborn Care o Nurse Mid-Wife Services o Family Nurse/Pediatric Nurse Practitioner o Free Standing Birth Center	ABP5 AEG	10	4
Mental Health and Substance Use Disorder Services Including Behavioral Health Treatment o Behavioral Health Services o Community Psychiatric Rehabilitation o Comprehensive Substance Treatment & Rehab (CSTAR) o Certified Community Behavioral Health Organization o Inpatient Psychiatric Facility Services (under 22) o Inpatient Hospital – Detoxification	ABP5 AEG	12-14	5
Prescription Drugs	ABP5 AEG	15	6
Rehabilitative and Habilitative Services and Devices o Inpatient Hospital – Rehabilitative o Skilled Nursing Facility Services o Durable Medical Equipment/Prosthetics o Complementary Med and Alternatives to Pain Management o Outpatient Hospital Cardiac Rehabilitation o Home Health o Habilitative Services o Personal Care Services	ABP5 AEG	16-18	7
Laboratory Services o Laboratory and X-Ray Services	ABP5 AEG	19	8
Preventive and Wellness Services and Chronic Disease Management o Preventative Care/Screening/Immunization o Diabetes Prevention Program Services	ABP5 AEG	20	9

State:

Pediatric Services Including Oral and Vision Care o Medicaid State Plan EPSDT Benefits	ABP5 AEG	21	9

State:

Citation	Condition or Requirement
1932(a)(5)(D)(b)(4) 42 CFR 438.228	J. ☒ The state assures that each MCO has established an internal grievance and appeal system for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	K. Services, including capacity, network adequacy, coordination, and continuity. ☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. ☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	M. ☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option. To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will ☒ will not ☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

State:

Citation	Condition or Requirement

2. ☒ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   Response: The state contracts with three Managed Care Organizations in order to provide sufficient access and coverage throughout the state. Limiting the number of contracted MCOs helps to provide a cohesive program for the number of participants in the program.

4. ☐ The selective contracting provision in not applicable to this state plan.

State:

Citation	Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

State:

Citation Condition or Requirement

Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. TBD)