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State/Territory Name: Missouri

State Plan Amendment (SPA) #: 23-0002

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS Form 179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

March 16, 2023

Mr. Todd Richardson
Director
MO HealthNet Division
Missouri Department of Social Services
P.O. Box 6500
Jefferson City, MO 65102-6500

Re: Missouri State Plan Amendment (SPA) 23-0002

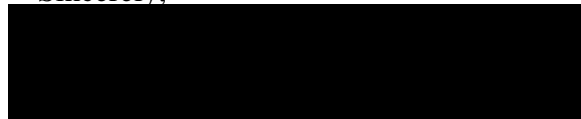
Dear Mr. Richardson:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0002. This amendment allows MO HealthNet to consider participants eligible for, but not enrolled in, a managed care plan for the Health Insurance Premium Payment (HIPP) program, and determine whether enrolling such participants in HIPP would be cost effective.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act at Section 1906. This letter is to inform you that Missouri Medicaid SPA 23-0002 was approved on March 16, 2023, with an effective date of April 1, 2023.

If you have any questions, please contact Michala Walker at 816-426-6503 or via email at Michala.Walker@cms.hhs.gov.

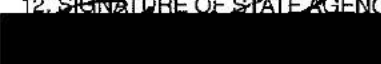

Sincerely,



James G. Scott, Director
Division of Program Operations

Enclosures

cc: Glenda Kremer
Becky McCarthy
Marissa Crump

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <div style="text-align: center;">2 3 — 00 0 2</div>	2. STATE <div style="text-align: center; font-size: 1.5em;">MO</div>
		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 <div style="font-size: 1.2em;">04/01/2023</div>	
		5. TYPE OF PLAN MATERIAL (Check One)	
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION Section 1906 of the Social Security Act		7. FEDERAL BUDGET IMPACT a. FFY 2023 \$ 0 b. FFY 2024 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.22C, Pages 1-3		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.22C, Pages 1-4, TN 96-44 22-0012	
10. SUBJECT OF AMENDMENT This amendment will allow MO HealthNet the ability to examine cases that are currently ineligible for the Health Insurance Premium Payment Program (HIPP) for cost effectiveness by allowing MO HealthNet to consider participants eligible for, but not enrolled in, a Managed Care Plan for the HIPP Program.			
11. GOVERNOR'S REVIEW (Check One)			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT SLV <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO MO HealthNet Division P.O. Box 6500 Jefferson City, MO 65102	
13. TYPED NAME Robert J. Knodell			
14. TITLE Acting Director			
15. DATE SUBMITTED <div style="font-size: 1.2em;">1/30/23</div> 2/1/23			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED February 1, 2023		18. DATE APPROVED March 16, 2023	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL April 1, 2023		20. SIGNATURE OF REGIONAL OFFICIAL 	
21. TYPED NAME James G. Scott		Director, Division of Program Operations	
23. REMARKS Boxes 6, 9, and 15: Changes authorized by State on 02/28/23.			

STATE METHODOLOGY FOR COST EFFECTIVENESS OF HEALTH PLANS

Missouri's formula for determining cost effectiveness of insurance plans under the Health Insurance Premium Payment Program (HIPP) program is modeled after the Secretary's methodology in the State Medicaid Manual, Section 3910. The formula is:

$$\text{Savings from the plan} = \text{GHPC} - \text{CSM}$$

DEFINITIONS:

Health Insurance Premium Payment (HIPP) Program – The HIPP Program is a premium assistance program that Medicaid participants may be eligible for if they have access to a group health insurance plan. Missouri operates a voluntary program where participants may choose to apply to participate in the program. Missouri's HIPP Program authority is pursuant to Section 1906 of the Social Security Act.

Group Health Insurance - any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees. A group health plan must meet section 5000(b)(1) of the *Internal Revenue Code of 1986*, as amended, and include continuation coverage pursuant to Title XXII of the Public Health Service Act, section 4980B of the *Internal Revenue Code of 1986*, or Title VI of the Employee Retirement Income Security Act of 1974, as amended.

CSM - Computer Summed Medicaid Costs: Average Medicaid expenditures (only for the services covered under the insurance plan) from the previous fiscal year, for persons with like demographic data and no third party resources, excluding Medicare.

Determine average Medicaid cost for each Medicaid-eligible person in the household by the following demographic data:

1. Age - As Tabled
2. Sex - Male/Female
3. Types of Assistance – Medicaid Eligibility (ME) Code
4. Geographic Location – Statewide average
5. Category of Service - As Tabled

GHPC - Group Health Plan Costs: Calculate total costs to the State under the group health

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plan. GHPC consists of the following formula:

$$EP + AC = GHPC$$

EP: Annual premium amount + annual policy cost sharing

AC: Administrative Cost - \$100 annually per recipient

If the formula indicates that the policy is not cost effective based on average Medicaid expenditures for similar households, the specific health-related circumstances of the household are examined. Health insurance will be purchased if the household's anticipated medical expenditures are greater than the average and would cause the policy to be cost-effective.

TABLE OF AGE GROUPS

#1	0
#2	1 - 4
#3	5 - 14
#4	15 - 19
#5	20 - 45
#6	46-65
#7	66- 79
#8	80+

TABLE OF CATEGORY OF SERVICES

Inpatient Hospital	Lab & Radiology	Medicare Suppl.
Outpatient Hospital	Ambulance	Nursing Homes
Physician	Emergency Room	Hospice
Clinic	DME	ICF/MR Service
Drugs	Home Health	Skilled Nurse
Psychiatric / Psychology	Dental	Optical

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Participants are not eligible for Premium Assistance if they are eligible for or enrolled in Medicare.

Participants are not eligible for Premium Assistance if they are enrolled in the following:

MO HealthNet Managed Care; or
Court Ordered Health Insurance.

Dental and Vision insurance policies will not be eligible for premium assistance unless the benefits are part of the medical policy and cannot be separated from the medical policy premium. Dental and Vision benefits will be provided to participants through wrap around coverage.

Payment for premiums will be made prospectively to the insurance carrier. If payment to the insurance carrier is not possible, payment will be made to the employer for employer based policies. In the event these options are not available payment may be made to the policyholder. The policyholder shall provide documentation of continuing coverage on a monthly basis.

The department shall be entitled to any refund from the health insurance carrier, due to overpayment or payment of an inactive policy, for any time period for which the department paid.

Payment for cost sharing will be made prospectively to the policyholder. The HIPP program shall be notified of upcoming Medicaid-covered services, and associated cost sharing obligations, at least three (3) weeks prior to date of service in order to receive prospective payment for any cost sharing obligation. Payment for cost sharing related to services obtained without notice to the HIPP program will be reimbursed. Documentation supporting the services occurred, and cost sharing payment made, must be submitted to the department by the end of the month following the date of service. Cost sharing payment will be made only for services obtained by Medicaid participants. Family members who are not Medicaid eligible, but are covered through the policy, are not eligible to receive payment for cost sharing.

Participants in the HIPP program are eligible for all benefits available to their eligibility group under the Medicaid state plan or section 1115 demonstration. Participants in the HIPP program will access benefits covered by both the HIPP policy and Medicaid by ensuring their providers are in-network for the HIPP policy and presenting both insurances to providers when they obtain services. If the HIPP policy does not cover a service, but Medicaid does, the participant will obtain services from a Medicaid provider.

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