

Missouri Medicaid Basics

SPRING 2019

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Acronym Key

ACA	Affordable Care Act
AFDC	Aid for Families with Dependent Children
CCBHC	Certified Community Behavioral Health Clinics
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DHSS	Missouri Department of Health and Senior Services
DSS	Missouri Department of Social Services
DMH	Missouri Department of Mental Health
EFMAP	Enhanced Federal Medical Assistance Percentage
FFY	Federal fiscal year
FMAP	Federal Medical Assistance Percentage
FPL	Federal poverty level
FSD	Missouri Family Support Division
HCB	Home-and community-based
MACRA	Medicare Access and CHIP Reauthorization Act
MAGI	Modified adjusted gross income
MHABD	MO HealthNet for the Aged, Blind, and Disabled
MHF	MO HealthNet for Families
NEMT	Non-emergency medical transportation
OAA	Old Age Assistance
QMB	Qualified Medicare Beneficiary
SFY	State fiscal year
SLMB	Specified Low-Income Medicare Beneficiary
SSI	Supplemental Security Income

Missouri's MO HealthNet

- Covers 1 out of every 6 Missourians
- Covers 45% of Missouri's children
- Pays for 38% of all births in the state²
- Covers 1 out of every 13 adults age 65 and over
- Pays for 65% of all nursing home care in the state³
- Provides access to medical treatment for over 976,000 Missourians

Introduction

The Medicaid program, enacted through Title XIX of the federal Social Security Act in 1965 at the same time as Medicare, exists as the largest of the federal-state partnerships for low-income people. Nationally, Medicaid and the Children’s Health Insurance Program (CHIP) provide public health insurance coverage to over 73 million low-income Americans,¹ including working families, older adults, and individuals with physical and mental disabilities. The federal government offers matching funds to states to support the financing of Medicaid.

Each state administers its own Medicaid program. The federal Centers for Medicare and Medicaid Services (CMS) monitors state-run programs and establishes requirements for service delivery and quality, funding, and eligibility standards. State participation is voluntary, and all states have participated since 1982. Missouri’s participation in Medicaid (called MO HealthNet in Missouri) began in 1967.

Overview of MO HealthNet

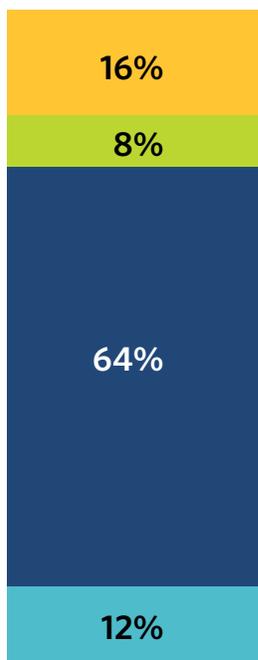
The Missouri Department of Social Services (DSS), MO HealthNet Division, administers the provision and payment of services for Missouri’s MO HealthNet program. The DSS Family Support Division (FSD) determines MO HealthNet eligibility for individuals and families. There are 144 FSD resource centers located throughout Missouri (an interactive map of the FSD resource centers can be found at: http://dss.mo.gov/dss_map/).

MO HealthNet represents a significant portion of Missouri’s overall state budget. Approximately 29 percent of Missouri’s total budget was dedicated to MO HealthNet in State Fiscal Year (SFY) 2018. More than 49 percent of the state’s Medicaid funding comes from federal funds. MO HealthNet spending varies with policy changes to enrollment, covered benefits, and eligibility guidelines as well as with other factors such as consumers’ health status, unemployment rates, and medical price inflation. Such factors are also likely to impact the overall state budget given the size of the MO HealthNet program.

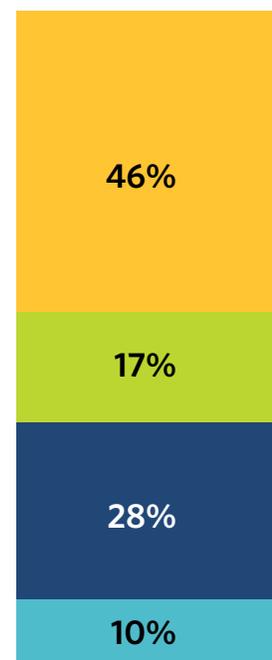
MO HealthNet Expenditures by Eligibility Group

Although most people enrolled in MO HealthNet are families and children, the majority of expenditures pay for services to aged, blind, and disabled Missourians.

Share of Enrollment



Percent of Expenditures



Missouri Medicaid Eligibility

Children (up to age 19)	<305% FPL
Parents	~22% FPL**
Pregnant Women	<201% FPL†
Individuals with a Disability	<85% FPL***
Missourians Age 65 & Older	<85% FPL***
Blind Individuals	<100% FPL***
Qualified Medicare Beneficiaries	<100% FPL

*Asset tests and other factors affect eligibility, which is determined by the FSD.

**Income guidelines for parents are based on the July 1996 AFDC payment standard, not on the federal poverty guidelines.

***Deductions and exceptions apply. People may have medical expenses deducted from income calculations to “spend down” to eligibility levels.

† The income guidelines listed for pregnant women exclude Missouri’s Show-Me Healthy Babies Program, which provides pregnancy-related services to women with incomes between 201 and 305% FPL.

Children, pregnant women, and parents are subject to a 5% income disregard as a result of changes made in the ACA to amend MAGI used to determine eligibility.

2018 Federal Poverty Level

Family Size	Annual Income			
	85% FPL	100% FPL	201% FPL	305% FPL
1	\$10,319	\$12,140	\$24,401	\$37,027
2	\$13,991	\$16,460	\$33,085	\$50,203
3	\$17,663	\$20,780	\$41,768	\$63,379
4	\$21,335	\$25,100	\$50,451	\$76,555

AFDC Payment Standard for Parent Eligibility (~22% FPL)

Annual Income	Family Size			
	2	3	4	5
	\$3,720	\$4,656	\$5,496	\$6,276

Eligibility

In general, MO HealthNet covers low-income children; their parents, guardians, or caretakers; and aged, blind, or disabled individuals when income and resource requirements are met. Income criteria are primarily based on poverty guidelines established by the federal government. Resource criteria (e.g., savings and other countable assets) largely apply only to MO HealthNet for the Aged, Blind, and Disabled (MHABD).

Parents, Children, and Pregnant Women

In SFY 2018, MO HealthNet covered 620,294 low-income children and 97,582 low-income custodial parents. The vast majority of covered adults in families with children are women. Children represent the largest demographic group served by Missouri Medicaid, with almost 64 percent of all MO HealthNet enrollees being age 18 or younger. Pregnant women who meet certain income criteria are also eligible for coverage during their pregnancy and postpartum.

Aged

More than 80,500 Missourians age 65 and over were covered by MO HealthNet in SFY 2018. Eligible individuals must meet the income and resource requirements of the program. Older adults can also “spend down” their incomes to qualify for MO HealthNet (see “What’s Meant by Spending Down” for more information). In some cases, MO HealthNet assists older adults in paying their Medicare premiums, copayments, and deductibles.

Blind and Disabled

An estimated 156,057 Missourians covered by MO HealthNet qualify for services due to a “physical or mental impairment, disease, or loss which keeps them from working in any job within their skill level for 12 months or longer.” People who are eligible for cash assistance through the federal Supplemental Security Income (SSI) program automatically qualify for MO HealthNet on the basis of disability. Other individuals who meet the SSI disability definition are also eligible as long as their income does not exceed 85 percent of the federal poverty level (FPL) for individuals with a disability and 100 percent of FPL for those who are blind. Additional people can qualify by spending down their incomes on medical expenses. Some people with a disability also receive MO HealthNet assistance to help pay their Medicare premiums, copayments, and deductibles.



Key MO HealthNet Programs

MO HealthNet refers to the statewide medical assistance programs for older adults and people with disabilities, low-income families, pregnant women, and children. MO HealthNet enrollees receive their health care through either the fee for service or the managed care delivery systems. MO HealthNet includes both federally matched and state-only funded programs. The following sections discuss the six largest programs that together covered 97 percent of the individuals enrolled in MO HealthNet.*

1. MO HealthNet for the Aged, Blind, or Disabled

MHABD provides Medicaid coverage to individuals who meet the requirements of the Old Age Assistance (OAA), Permanently and Totally Disabled, or Aid to the Blind programs. These Missourians account for 22 percent of all MO HealthNet consumers. Individuals who are 65 and older or disabled and have incomes up to 85 percent of FPL qualify automatically, while others qualify for MHABD by spending down their incomes on medical expenses each month. Persons who are blind automatically qualify for MO HealthNet if they have incomes up to 100 percent of FPL. These individuals may also spend down to qualify.

Approximately 30 percent of individuals covered under MHABD are eligible under the OAA requirements (around 65,215 persons), while only about 0.5 percent of individuals (around 1,100 persons) in the MHABD program are eligible under the Aid to the Blind program. Individuals with disabilities account for 69 percent of participants in the MHABD program (around 148,216 persons). People of all ages with a wide variety of physical and mental disabilities can qualify if their disability, income, and resources meet certain criteria.

2. Medicare Cost Savings Programs

The federal government requires that state Medicaid programs pay Medicare premiums, deductibles, or coinsurance for qualified people enrolled in Medicare Parts A or B. The Missouri Qualified Medicare Beneficiary (QMB) program pays for Medicare premiums, deductibles, and coinsurance for eligible persons enrolled in Medicare Part A with incomes up to 100 percent of FPL. Around 102,700 individuals received benefits through the QMB program in June 2018. Eighty-six percent of QMB recipients also received MHABD coverage.

Additionally, Missouri has a Specified Low-Income Medicare Beneficiary (SLMB) program that pays for all or part of the Medicare Part B premiums for persons whose incomes are more than 100 percent of FPL, but not exceeding 120 or 135 percent of FPL. In June 2018, 36,636 individuals received assistance under the SLMB program. Thirty-three percent of SLMB recipients also received MHABD coverage.

3. MO HealthNet for Kids (Medicaid)

This program provides health insurance coverage for children under age 19 whose net family income does not exceed:

- 201 percent of FPL for children under age 1, and
- 153 percent of FPL for children ages 1-18.

Approximately 549,214 low-income Missouri children have health insurance coverage through this MO HealthNet program. This population represents 57 percent of all MO HealthNet recipients. (Note: about 32 percent of these children are classified under MO HealthNet for Families – Children because their parents are also eligible for MO HealthNet; however, they are eligible because of the above income requirements.)

* Enrollment data presented for the Key MO HealthNet Programs is from June 2018. Eligibility guidelines include the 5 percent income disregard.

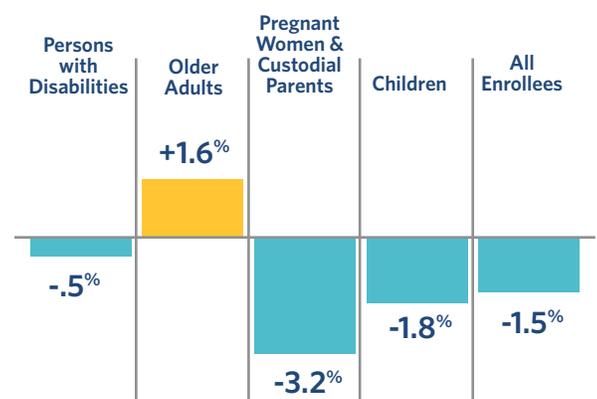
What's Meant by "Spending Down?"

Spending down refers to the amount of medical expenses that an individual must pay each month before becoming eligible for coverage through Medicaid. The total that must be spent down equals the amount by which an individual's or couple's net income exceeds the income eligibility requirement for a given Medicaid program.

An individual's spend down obligation can be met by:

- submitting incurred medical expenses to their caseworker monthly;
- paying the monthly spend down amount to the MO HealthNet Division, similar to an insurance premium payment; or
- concurrently submitting incurred medical expenses and paying a monthly spend down amount to the MO HealthNet Division.

SFY 2017-2018 MO HealthNet Enrollment Change



Missouri's CHIP Program

The federal Balanced Budget Act of 1997 amended the Social Security Act to create Title XXI, CHIP. CHIP provides affordable health coverage to 8.9 million children nationally, including over 28,000 in Missouri, who live in families with incomes too high to qualify for Medicaid but too low to afford private coverage. In Missouri, the program is called MO HealthNet for Kids (CHIP).

In April 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed by Congress and signed into law by then-President Obama. The law extended CHIP through September 30, 2017, and provided an additional \$19.3 billion for federal fiscal year (FFY) 2016 and \$20.4 billion for FFY 2017. In addition, MACRA maintained the previous payment formula, which included a 23-percentage-point increase in the federal government's CHIP match rate to the states. On September 30, 2017, Congress allowed CHIP funding to expire. Funding was re-authorized on January 22, 2018, when Congress extended funding of CHIP through FFY 2023. The extension also maintained the enhanced federal match rate. Currently, under the enhanced federal match rate, the federal government pays 98.8 percent of CHIP expenditures in Missouri.⁴



4. MO HealthNet for Kids (CHIP)

Using its allocated CHIP funds, Missouri expanded the existing Medicaid program for low-income children in 1998. This CHIP expansion extended health coverage to low-income children with family income up to 305 percent of FPL.

The MO HealthNet for Kids (CHIP) program provides the same health services as those covered under MO HealthNet for Kids (Medicaid), except that CHIP kids are not eligible for non-emergency medical transportation (NEMT). Based on an income scale, some individuals covered under Missouri's CHIP program must pay premiums. Premiums paid per family per month range from \$0 to \$316 for families with six members or less (see "MO HealthNet for Kids by Age and Income with Premium Requirements" chart). Around 28,522 children had coverage under the MO HealthNet for Kids (CHIP) program in Missouri. This number represents about 3 percent of the total MO HealthNet population.

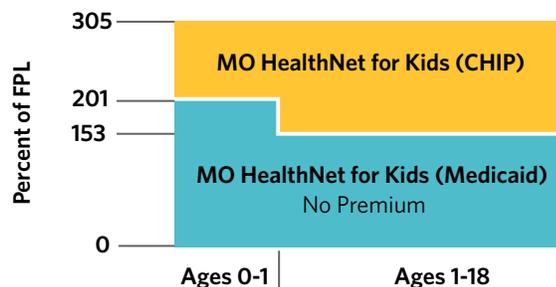
5. MO HealthNet for Families - Adults

Low-income parents and caretakers are covered through the MO HealthNet for Families (MHF) adult program. Parents with incomes up to the 1996 Aid to Families with Dependent Children (AFDC) income level (about 22 percent of FPL) are eligible for the program. As of June 2018, 92,514 adults had health insurance coverage through the MHF program. This group represents 9 percent of all MO HealthNet recipients in the state of Missouri.

6. MO HealthNet for Pregnant Women

Pregnant women with family incomes up to 201 percent of FPL qualify for Medicaid coverage under the MO HealthNet for Pregnant Women program. Qualification under this category includes 60-day postpartum coverage even with subsequent increases in family income. Approximately 25,115 women received insurance benefits under this program in June 2018. This group represents nearly 3 percent of all MO HealthNet recipients in the state. In 2014, the General Assembly passed legislation creating the "Show-Me Healthy Babies" program in MO HealthNet. This program covers unborn children by expanding health coverage to pregnant mothers. Show-Me Healthy Babies covers pregnancy-related services for women with incomes between 201 and 305 percent of FPL. Around 2,674 women were enrolled in this program at the end of SFY 2018.

MO HealthNet for Kids by Age and Income with Premium Requirements

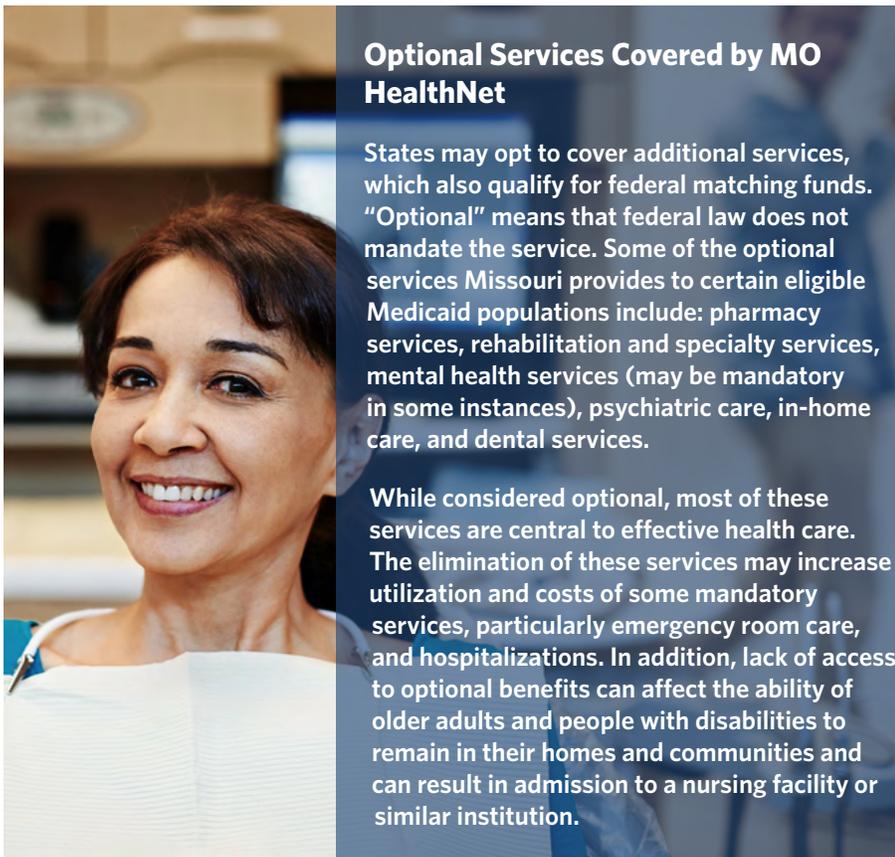


Family income and size determines the premium.
A family pays no more than 5 percent of their income for coverage.

Mandatory MO HealthNet Services

Federal guidelines require states to cover a minimum set of services under Medicaid, including:

- inpatient hospital services;
- outpatient services, including those delivered in rural health clinics and federally qualified health centers;
- physician services, including psychiatry;
- family planning services and supplies;
- nursing facility services and home care;
- skilled home health services, including durable medical equipment;
- lab and X-ray services;
- nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services;
- medical and surgical services of a dentist;
- NEMT; and
- screening and treatment services to children under age 21 under the Early and Periodic Screening, Diagnostic, and Treatment program, also known as the Healthy Children and Youth program in Missouri.



Optional Services Covered by MO HealthNet

States may opt to cover additional services, which also qualify for federal matching funds. "Optional" means that federal law does not mandate the service. Some of the optional services Missouri provides to certain eligible Medicaid populations include: pharmacy services, rehabilitation and specialty services, mental health services (may be mandatory in some instances), psychiatric care, in-home care, and dental services.

While considered optional, most of these services are central to effective health care. The elimination of these services may increase utilization and costs of some mandatory services, particularly emergency room care, and hospitalizations. In addition, lack of access to optional benefits can affect the ability of older adults and people with disabilities to remain in their homes and communities and can result in admission to a nursing facility or similar institution.

Non-Emergency Medical Transportation

Federal law requires states to ensure that eligible Medicaid enrollees have access to NEMT to and from providers. Transportation is provided to scheduled Medicaid-covered appointments but is not available for all services covered by Medicaid.

NEMT may not be used for home health services, travel to a pharmacy, or for services provided as part of a 1915(c) HCB waiver. NEMT is also not available to blind pension, women's health services, state-only funded child welfare services, and CHIP enrollees.

NEMT is available to enrollees who do not have access to other transportation that is free, provided through Medicare, or provided by a hospice provider.⁵

NEMT uses public transportation, vans, taxi, and ambulance (for non-emergency purposes). Services are managed by brokers who coordinate transportation providers.⁶ In Missouri, there is a broker for fee-for-service enrollees and managed care enrollees. Brokers are responsible for coordinating efficient and affordable transportation for enrollees. NEMT services require advance reservation of two to three business days depending on the geographic region.

In 2016, MO HealthNet awarded a new fee-for-service NEMT contract to Logisticare Solutions, LLC. The five-year contract included changes aimed at improving NEMT services for MO HealthNet enrollees, including reduced reservation times and the provision of urgent rides to care. In 2017, there were on average more than 330,000 quarterly trips made for fee-for-service enrollees.

MO HealthNet Waivers

States have flexibility when it comes to designing and running Medicaid and CHIP. However, federal law sets minimum standards for operating the programs. States can change their programs through a state plan amendment or a waiver. State plan amendments are used when a state is making a change to how Medicaid is administered within the requirements of federal law.

States can also request to “waive” certain provisions of sections 1115 and 1915 of the Social Security Act. The “waiver” is an agreement between the federal government and the state that exempts the state from the provisions of the federal law. The waiver includes special terms and conditions that define the strict circumstances under which and for whom the state is exempt from the provisions of federal law. Missouri currently has ten 1915(c) home-and community-based (HCB) waivers, a 1915(b) waiver authorizing the managed care system, and one active 1115 waiver.

Missouri's 1115 Waivers

Missouri has one active 1115 waiver that authorizes the Gateway to Better Health demonstration in St. Louis City and County. The demonstration expands coverage to individuals ages 19-64 with income up to poverty level. The demonstration began in 2010 and has been extended through 2022.

From 2007-2017, Missouri had a 1115 waiver for the Women’s Health Services Program. The program expands coverage to uninsured women ages 18-55 years old who would otherwise lose their MO HealthNet eligibility 60 days after the birth of their child. In 2016, the Missouri General Assembly passed legislation to restrict organizations that provide abortion services from participating in the program. The provider restrictions violate the terms and conditions of the federal waiver, and as a result, the 1115 waiver ended in 2017. The Women’s Health Services Program still exists but now operates using only state funds.

In 2018, the Missouri General Assembly passed legislation for Postpartum Substance Use Treatment that will require a 1115 waiver and CMS approval. If approved, the waiver will extend MO HealthNet postpartum coverage for substance use and related mental health treatment from 60 days to 12 months. To qualify for extended coverage, women must receive substance use treatment within 60 days of giving birth and remain adherent with treatment throughout the coverage period.⁸

Requirements for Medicaid Waivers and State Plan Amendments

	State Plan Amendment	1915(c) Waiver	1915(b) Waiver	1115 Waiver
Scope of Change	Allows states to update administrative operations in accordance with federal requirements (i.e. eligibility, benefits, services, provider payments, etc.)	Allows states to offer HCB services	Allows states to modify delivery systems (e.g. managed care)	Allows states to conduct demonstrations that further the goals of the Medicaid program
Public Review	Not required	Encouraged	Encouraged	Required public comment period
Budget Requirements	No cost or budget requirement	Cost neutrality required	Cost effectiveness required	Budget neutrality required
Federal Government's Approval Timeframe	90 days	90 days	90 days	No required timeframe
Approval Duration	Indefinite	3 years; renewals up to 5 years	2 years; renewals up to 2 years	5 years; renewals up to 3 years ⁷

Delivery Systems

Missouri's MO HealthNet program works to promote good health, to prevent illness and premature death, to correct or limit disability, to treat illness, and to provide rehabilitation to persons with disabilities. Health services covered by MO HealthNet can be split into two benefit packages: 1) Primary and Acute Health Care and 2) Long-Term Services and Supports.

Primary and Acute Health Care

MO HealthNet's Primary and Acute Health Care package provides physician, hospital, laboratory, pharmacy, preventive, and other services. People have access to these services through either the fee-for-service system or the managed care system, depending on the MO HealthNet program for which they are eligible.

Fee for Service

In Missouri, all individuals eligible under the MHABD program participate in the fee-for-service system regardless of their county of residence. Missouri DSS, through the use of a claims processing fiscal agent, pays for services based on an established fee schedule.

Prior to 2017, MO HealthNet children and parents that lived in counties other than those designated as managed care counties also participated in the fee-for-service system. Currently, all children*, parents, and pregnant women participate in Missouri's Medicaid managed care system. All MO HealthNet enrollees, however, still obtain prescriptions and behavioral health services through the fee-for-service system.

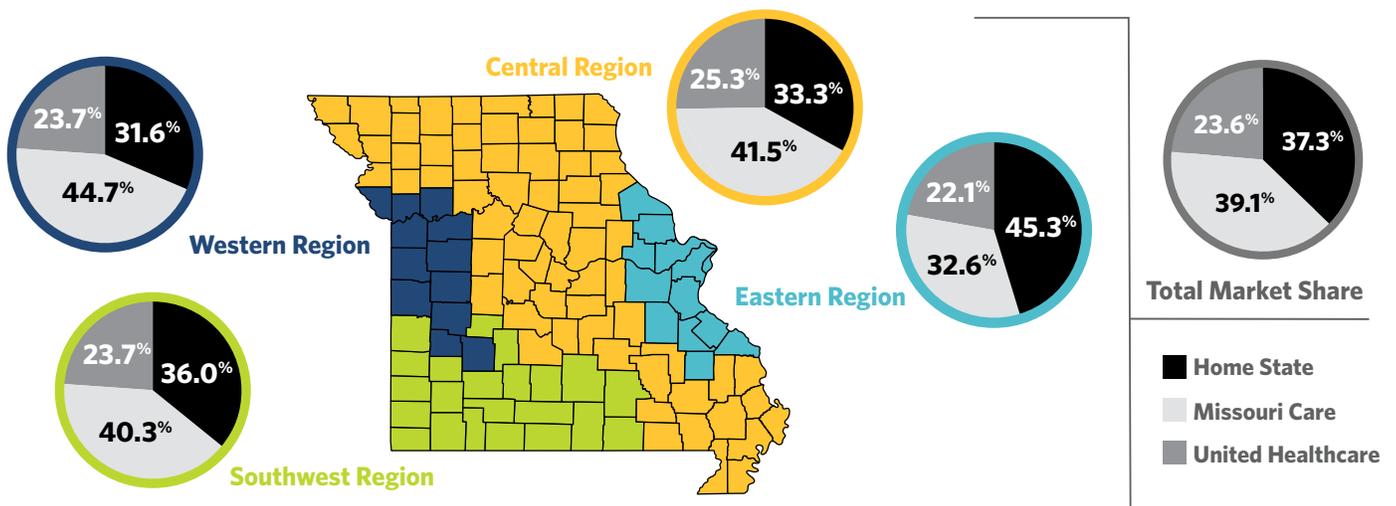
MO HealthNet Managed Care

The MO HealthNet managed care system (formerly known as MC+) started in 1995 when Missouri DSS first contracted with managed care plans in an effort to improve the accessibility and quality of health care services for Missouri's MO HealthNet populations, while improving predictability of the costs associated with providing care. Missouri initially used managed care plans to deliver Medicaid benefits to children, families, and pregnant women across a specific geographic corridor of 54 counties that spanned the center of the state and included the cities of St. Louis, Columbia, Jefferson City, and Kansas City.

On May 1, 2017, Missouri expanded Medicaid managed care to include all 114 counties and the city of St. Louis for that same population (children, families, and pregnant women). In preparation for the expansion, Missouri revised its MO HealthNet Health Plan request for proposals and issued new contracts with three managed care companies. The MO HealthNet managed care plans include: Home State Health Plan (Centene), Missouri Care (WellCare), and UnitedHealthcare. Prior to the statewide expansion, Missouri also contracted with Aetna Better Health of Missouri which covered an estimated 55 percent of people enrolled in the MO HealthNet managed care system.

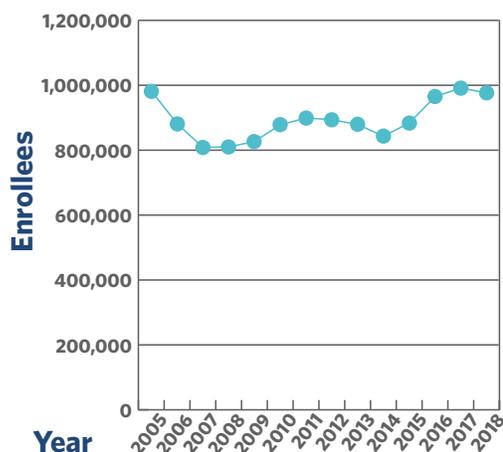
MO HealthNet Managed Care Enrollment by Regions*

* Enrollment as of June 2018



* Individuals with disabilities and children in foster care have the option to use fee for service or managed care.

Changes in MO HealthNet Enrollment SFY 2005 - 2018



All MO HealthNet recipients must enroll in a managed care health plan if they fit into one of the following eligibility categories:

- parents/caretakers, children, pregnant women, and refugees;
- other MO HealthNet children who are in the care and custody of the state and receive adoption subsidy assistance; and
- CHIP children.

As of June 2018, more than 70 percent of MO HealthNet beneficiaries were enrolled in one of the three contracted MO HealthNet managed care plans. People who are eligible for the MO HealthNet managed care system can choose one of the plans during open enrollment. If no selection is made, Missouri will automatically assign individuals to a plan. Missourians can change their MO HealthNet managed care plan during the first 90 days for any reason. After this grace period, enrollees may request a change under specific circumstances.

The contracted managed care plans provide a particular range of benefits to each enrolled recipient in return for a capitated payment from the state made on a per member per month basis. The MO HealthNet managed care system along with federal regulatory changes mandate different safeguards to ensure beneficiaries obtain accessible care. Additional information on the requirements of managed care plans can be found in the MFH publication, Medicaid Managed Care Final Rule: Implications for Missouri at <http://bit.ly/2jAEqEs>.



Long-Term Services and Supports

MO HealthNet provides long-term services and supports to people who have chronic or disabling conditions and meet certain “level-of-care” criteria. These services fall into two categories based on the setting of service delivery. Medicare and private insurance rarely cover long-term services and supports; therefore, Medicaid is the primary source of coverage.

Facility-Based Care

Facility-based nursing care covers services provided in certain residential settings and accounts for one of the largest portions of MO HealthNet costs. Medicaid also covers care in residential facilities for eligible people with developmental disabilities, including intellectual disability. To qualify, individuals need a planned program of active treatment, must live in a licensed facility, and must meet certain other criteria. A large majority of Missourians living in intermediate care facilities for individuals with intellectual disabilities are MO HealthNet consumers.

Community-Based Care

Missouri's MO HealthNet program supports a number of waivers that allow certain consumers to receive care in their homes or in the community rather than in a nursing facility or other institution. HCB services have eligibility requirements based on income, resources, and level of care required.

Missouri currently has 10 HCB waiver programs that receive funding from state general revenue, social services block grants, Medicaid, and the Older Americans Act. Authorization for waiver services comes through either the Missouri Department of Health and Senior Services (DHSS)* or the Missouri Department of Mental Health (DMH)** which determine need for care and the availability of services.

The Missouri HCB waiver programs include the:

- Adult Day Care Waiver;*
- Aged and Disabled Waiver;*
- AIDS Waiver;*
- Independent Living Waiver;*
- Medically Fragile Adult Waiver;*
- Autism Waiver;**
- Developmental Disabilities (DD) Comprehensive Waiver;**
- Division of DD Community Support Waiver;**
- Missouri Children with Developmental Disabilities Waiver;** and
- Partnership for Hope Waiver.**

An estimated 80 percent of adults over age 50 want to live in their homes and communities as they age.⁹ Home care is also less expensive for MO HealthNet than institutional care. Because those who enter institutional care settings generally do not return home, prevention of institutional care is important. The HCB waivers help individuals remain integrated in their communities as they age while also preventing utilization of higher-cost services.

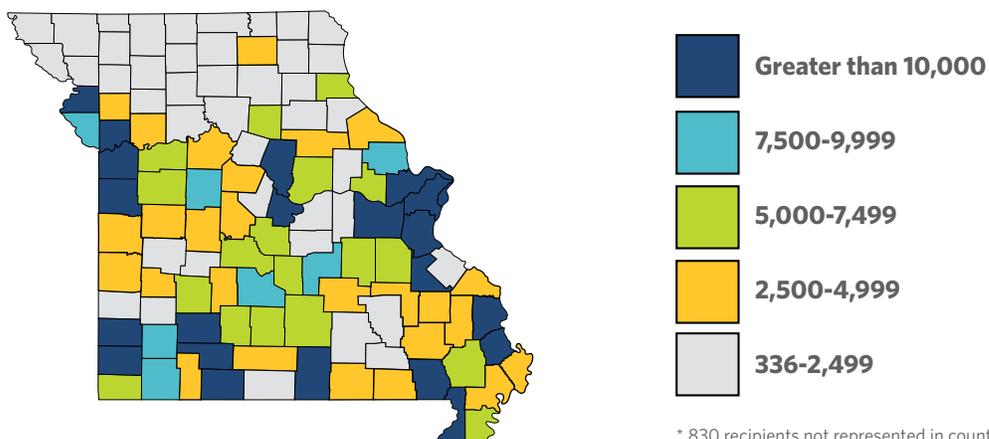
Changes to HCB Eligibility and Scope of Services

Beginning in SFY 2018, MO HealthNet policies for HCB services changed in response to reduced state funding. Older adults and people with disabilities qualify for HCB services based on income, resources, and a level-of-care determination. An assessment assigns a score based on the amount of assistance an individual requires and the complexity of required care. Higher scores indicate more required assistance and more complexity in care. To qualify for HCB services, the required level-of-care score increased from 21 to 24 points. Individuals with scores below 24 are not eligible for HCB services. According to federal requirements, the level of care score for facility-based services in MO HealthNet also changed to 24.

MO HealthNet's consumer-directed services assist individuals with physical disabilities with activities of daily living and instrumental activities of daily living as an alternative to nursing facility care. These services include bathing, dressing, toileting, turning/positioning, transfers to bed or bathroom, medication assistance, etc. Consumer-directed services can no longer exceed 60 percent of the average monthly cost of nursing facility care. Previously, the limit was 100 percent of the average monthly cost of nursing facility care. The changes in MO HealthNet's HCB eligibility and scope of services will cause individuals to lose coverage and may result in more utilization of facility-based care.

Population Enrolled in MO HealthNet by County

As of June 2018, approximately 16% of Missourians (1,012,049 individuals) were enrolled in MO HealthNet.



* 830 recipients not represented in county maps due to invalid county in data

Financing and Expenditures

Medicaid and CHIP are financed jointly between the federal and state government. In federal fiscal year (FFY) 2016, health care spending in the United States on the Medicaid and CHIP programs totaled \$565.5 billion and \$16.9 billion, respectively.

MO HealthNet Financing

In general, there are three different levels of federal matching funds for MO HealthNet. They are the Federal Medical Assistance Percentage (FMAP), the Enhanced Federal Medical Assistance Percentage (EFMAP), and MO HealthNet administrative costs for which the federal government pays 50 percent of expenditures. FMAP covers the majority of MO HealthNet programs, while EFMAP is for the MO HealthNet for Kids (CHIP) program. Currently, under EFMAP the federal government pays 98.8 percent of CHIP expenditures in Missouri. The federal match rate for Missouri's FMAP is 65.4 percent for FFY 2019.¹⁰

The enacted state budget for SFY 2019 appropriated approximately \$7.8 billion for MO HealthNet. Yet, only \$1.3 billion of this cost comes from state general revenue. The majority of Medicaid financing, \$3.8 billion, stems from federal funds. The remaining balance of MO HealthNet financing derives from several nongovernmental sources, including provider taxes (e.g., hospitals and nursing homes), premiums, and tobacco funds (see "Sources of MO HealthNet Funding" for more information).

MO HealthNet Expenditures

In SFY 2018 MO HealthNet spent \$7.7 billion or about 81 percent of its budget on:

- hospitals (\$1.2 billion);
- pharmacy (\$ 1.4 billion);
- managed care (\$2.2 billion);
- nursing facilities (\$1.1 billion);
- mental health services (\$1.5 billion); and
- physician related services (\$452 million).

Although families and children constitute 76 percent of all MO HealthNet enrollees, this population uses only 37 percent of all Medicaid resources. By contrast, older adults and people with disabilities comprise 24 percent of all MO HealthNet enrollees but use 63 percent of all expenditures.

Annual MO HealthNet Expenditures by Population and Individual per Month Costs, SFY 2018			
	Enrollees	Annual Expenditures (in millions)	Average Monthly Cost Per Enrollee (dollars)
Older Adults	80,509	\$1,596	\$1,652
Persons with Disabilities	156,057	\$4,336	\$2,315
Children	620,294	\$2,595	\$321
Adults (non-disabled and under 65)	119,919	\$900	\$676



National Spending and Enrollment Growth

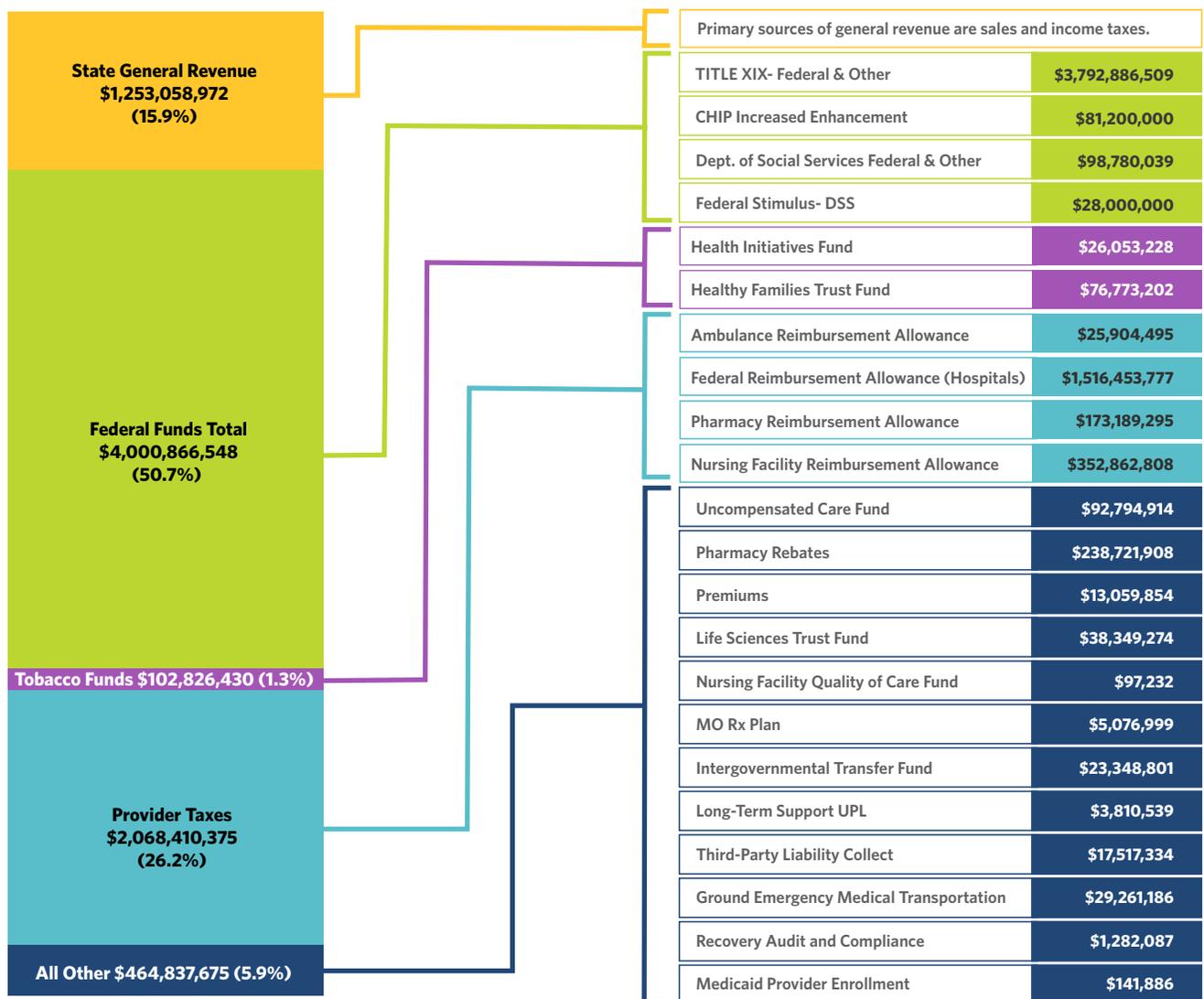
Following the implementation of the Affordable Care Act (ACA) and the expansion of Medicaid in certain states, Medicaid enrollment across the country surged in FFY 2015 with a 13.4 percent increase since FFY 2014. As a result, state and federal Medicaid expenditures also increased by 10.5 percent. In FFY 2017, enrollment growth rate slowed to 2.7 percent, down from 3.9 percent in FFY 2016.

The spending growth rate also slowed after implementation of the ACA. In 2016, total Medicaid spending increased by 3.5 percent, down from 10.5 percent in 2015 and 6.8 percent in 2014. State Medicaid expenditures grew by 2.4 percent in 2016, down from 3.8 percent in 2015.

These trends amount to over 73 million Americans covered by Medicaid or CHIP in 2018, with spending totaling \$557 billion in FFY 2017. Of this amount, the federal government paid approximately 62 percent with states paying the remaining 38 percent.

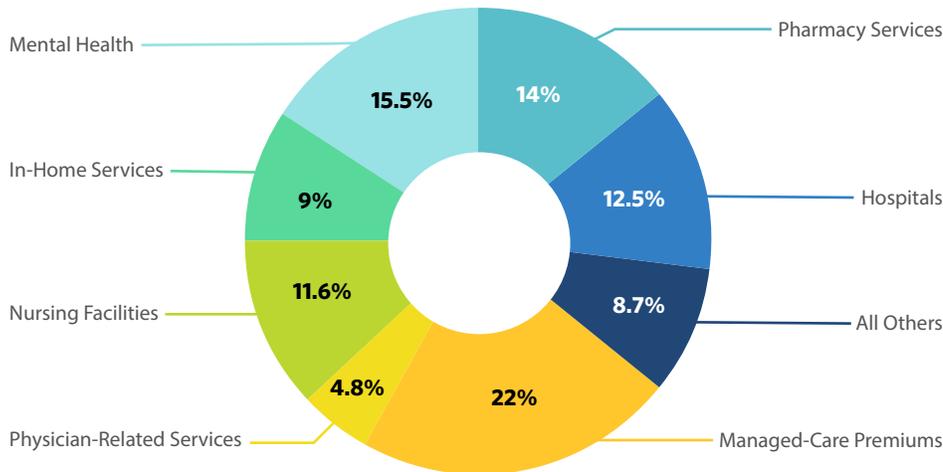
It is projected that the growth rate for federal spending will continue to trend downward while state spending is expected to increase. Trends, such as the increase in the older adult population, increasing prescription drug costs, and provider rate increases are projected to increase state spending.¹¹

Sources of MO HealthNet Funding, SFY 2019* - Total \$7.89 Billion



*This represents the program budget for the MO HealthNet Division, it does not include administrative appropriations or Medicaid funds appropriated to other state departments such as DHSS or DMH.

MO HealthNet Spending by Key Component



Federal Health Reform

In March 2010, then-President Barack Obama signed federal health reform legislation into law. The ACA has far-reaching implications for the health care system, including prohibiting pre-existing condition exclusions; providing tax credits to individuals, families, and small businesses to make insurance more affordable; limiting cost sharing; closing the Medicare Part D “donut hole;” and creating state health insurance marketplaces.

Under the ACA, states can choose to expand Medicaid eligibility to all non-Medicare eligible individuals with incomes up to 138 percent of FPL. Expansion would include childless adults, a population that has never been eligible for Medicaid in Missouri. Through 2016, the federal government provided 100 percent of the funding for this expanded population. In 2017, the federal share decreased to 95 percent and then steps down each year until it reaches 90 percent federal funding in 2020 and beyond.¹⁰ As of November 2018, 37 states have adopted Medicaid expansion. Several states adopted Medicaid expansion through a ballot initiative instead of through the legislature. Missouri has not expanded MO HealthNet eligibility.

In 2017, Congress proposed health reforms to repeal and replace the ACA. Proposals included restructured funding for state Medicaid programs through per capita caps or block grants. Per capita caps would have set a maximum amount of federal funding per Medicaid beneficiary. Block grants would have allowed the federal government to provide Medicaid funding through a lump sum regardless of the number of beneficiaries. Despite several attempts, proposals to reform the ACA have not passed Congress.

President Donald Trump’s administration has certain authority to alter how states run their Medicaid programs, such as the power to grant waivers. The executive branch has provided flexibility on states’ ability to include certain personal and fiscal responsibility measures into waivers. Unlike previous administrations, the Trump administration has approved several waivers that allow states to incorporate work requirements into their Medicaid programs. Many other states have submitted waivers and are awaiting a decision from the federal government. Several pending waivers include provisions that have not been approved by previous administrations: drug screenings, eligibility time limits, and premiums with eligibility disqualifications if not paid.¹³ The administration’s waiver decisions will continue to set a precedent for states to utilize these and other elements in administering their programs. Such changes could have an impact on enrollment, eligibility, and cost.

For More Information About Medicaid

Missouri Medicaid Basics provides a brief outline of the Missouri MO HealthNet program. For more information about MO HealthNet, please visit the Missouri Department of Social Services, MO HealthNet Division at www.dss.mo.gov/mhd/index.htm.

Certified Community Behavioral Health Clinic Demonstration

In 2014, Congress passed the Protecting Access to Medicare Act, which, through Section 223, created a demonstration program for up to eight states to establish Certified Community Behavioral Health Clinics. CCBHCs were first defined by certain criteria set forth in the Excellence in Mental Health Act and are clinics that furnish a range of behavioral and mental health services to individuals with complex needs. In a collaborative effort, the Substance Abuse and Mental Health Services Administration, CMS, and the Assistant Secretary of Planning and Evaluation, awarded planning grants to 24 states at a total of \$22.9 million. Missouri received \$982,373 in 2015 to begin the planning process for a CCBHC demonstration.

In December 2016, Missouri was chosen as one of eight states to receive a two-year demonstration grant to begin implementation of the CCBHC plan. CCBHCs must offer a wide range of comprehensive behavioral health services, including but not limited to crisis mental health services; screening, assessment, and diagnosis; patient-centered treatment planning; and outpatient mental health and substance use services. These services are provided to individuals with either serious mental illness, emotional disturbances, long-term addiction, or substance use disorders. Under the demonstration grant, Missouri receives Medicaid reimbursement for treatment provided in CCBHCs through a prospective payment system. Clinics are also required to collect and report on 21 quality metrics for evaluation purposes.

Missouri's participation in the demonstration began in July of 2017. Fifteen clinics were chosen to participate along with two designated collaborating organizations. Approximately 80 percent of the selected clinics are associated with services areas designated as medically underserved areas. Medically underserved areas are geographies or populations designated by the Health Resources & Service Administration as having a shortage of primary care providers, high infant mortality, high poverty, or a high population of older adults.

Missouri's CCBHCs are projected to serve more than 127,000 people in 201 service locations. Of the anticipated consumers, 87,284 are projected to be Medicaid enrollees. All of the state's CCBHCs are required to adopt a trauma-informed approach. All participating clinics are also required to be recognized as community mental health center health care homes under the health home option. Missouri CCBHCs plan to meet the goals of the demonstration project by expanding access to community behavioral services through a focus on reducing homelessness, hospitalization, incarceration, and interaction with the criminal justice system.¹²

Summary

MO HealthNet impacts the lives of low-income children, families, older adults, and people with disabilities in Missouri. The availability of Medicaid reduces the number of uninsured Missourians and provides health insurance coverage for vulnerable populations who might not otherwise have health coverage. MO HealthNet supports the state's health care infrastructure by helping to reduce uncompensated care, promote earlier treatment in appropriate settings and reduce preventable hospitalizations, decrease unnecessary emergency room use, and support education and training in academic medical centers.¹¹

Missouri's MO HealthNet program exists as a complex system that affects the lives of individuals and families in every county across the state. Policymakers must consider that Medicaid is a collection of programs, services, and funding mechanisms. In many cases, an adjustment to one element of this system can have unintended effects or consequences on other elements. Changes can also impact the entire health care system and the economy since MO HealthNet is a major health insurance program. Understanding the basics of this system is an important step in addressing the health care needs of all Missouri residents.

Online Resources

- Center for Budget and Policy Priorities – www.cbpp.org/topics/health
- Centers for Medicare and Medicaid Services– www.cms.gov
- Families USA - www.familiesusa.org
- Kaiser Family Foundation’s Program on Medicaid and the Uninsured - www.kff.org/kcmu
- Missouri Department of Health and Senior Services – www.health.mo.gov
- Missouri Department of Mental Health – www.dmh.mo.gov
- Missouri Department of Social Services – www.dss.mo.gov/mhd
- National Academy for State Health Policy - www.nashp.org

Missouri Medicaid Basics

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Statistics come from the Missouri Department of Social Services unless otherwise indicated. All dollar figures are for SFY 2018 (July 1, 2017 – June 30, 2018) unless otherwise noted.

Endnotes

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