

Children and Adults Health Programs Group

June 16, 2020

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

Dear Mr. Richardson:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), MO-20-0011, submitted on June 11, 2020, has been approved.

In response to the COVID-19 public health emergency, Missouri requested to implement the following flexibilities effective March 1, 2020 through the duration of the public health emergency:

- Waive requirements related to timely processing of applications and renewals, including extending deadlines for families;
- Delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by a State or Federally-declared disaster area such that processing the change in a timely manner is not feasible. The state will continue to act on the changes in circumstance described in 42 CFR 457.342(a) cross-referencing 435.926(d);
- Provide an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status as long as the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period;
- Waive the state's lookback period and affordability test requirements, including the requirement to provide proof that a child does not have access to other affordable coverage;
- Continue coverage for current CHIP beneficiaries who are unable to pay premiums during the disaster, waive outstanding premiums, freeze scheduled increases in CHIP premiums, and waive the premium lock-out period; and
- Waive the state's effective date of coverage policy that requires children in families with income above 225 percent of the Federal poverty level (FPL) to wait 30 days for CHIP coverage to begin.

In the event of a future disaster, this SPA provides Missouri with the authority to implement the aforementioned temporary policy adjustments by simply notifying CMS of its intent, the

Page 2 – Mr. Todd Richardson

effective date and duration of the provision, and a list of applicable Governor or federally-declared disaster or emergency areas. While the state must provide notice to CMS, this option provides an administratively streamlined pathway for the state to effectively respond to an evolving disaster event.

Your title XXI project officer is Ms. Kristin Edwards. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
E-mail: Kristin.Edwards@cms.hhs.gov

If you have any questions, please contact Meg Barry, Acting Division Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

A handwritten signature in black ink, appearing to read "Amy Lutzky", written over a horizontal line.

Amy Lutzky
Acting Deputy Director

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

Response:

Effective date (date State incurs costs):

Initial Combination SCHIP State Plan Submission, SPA #3: September 1, 2007
SPA #4: Disapproved December 19, 2008
SPA #5: Effective May 1, 2009
SPA #6: Effective July 1, 2009
SPA #7: Withdrawn June 29, 2011
SPA #8: Effective July 1, 2011
MO-15-0009-CHIP: Effective January 1, 2016
MO-15-0010: Effective January 1, 2016
MO-15-0011: Effective January 1, 2016
MO-17-002: Effective May 1, 2017
MO-18-0015: Effective July 1, 2017
MO-19-0014: Effective July 1, 2018
MO-20-0011: Effective March 1, 2020

Implementation date (date services begin):

SPA #3: September 1, 2007
SPA #4: Disapproved December 19, 2008
SPA #5: May 1, 2009
SPA #6: July 1, 2009
SPA #7: Withdrawn June 29, 2011
SPA #8: Effective July 1, 2011
MO-15-0009-CHIP: Effective January 1, 2016
MO-15-0010: Effective January 1, 2016
MO-15-0011: Effective January 1, 2016
MO-17-002: Effective May 1, 2017
MO-18-0015: Effective July 1, 2017
MO-19-0014: Effective July 1, 2018
MO-20-0011: Effective March 1, 2020

SPA # MO-20-0011

Purpose of SPA: To implement provisions for temporary adjustments to policies and provisions related to enrollment, redeterminations, and premiums, for children in families living and/or working in disaster or emergency areas as designated by under any of the following authorities:

- The President of the United States pursuant to the National Emergencies Act or the Robert T.

Effective Date: March 1, 2020

Approval Date:

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Prior Approval Date: March 21, 2019

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Stafford Disaster Relief and Emergency Assistance Act;

- The Secretary of Health and Human Services under the authority provided in the Public Health Service Act;
- Disaster areas declared by the Federal Emergency Management Agency; or
- Any state of emergency or disaster declared by the governor of the State under any applicable legal authority.
- In the event of such emergency or disaster, the State will notify CMS that it intends to provide temporary adjustments to the aforementioned requirements and policies, the effective and duration date of such adjustments, and the applicable declared disaster or emergency area. Such adjustments may be made retroactively to the beginning of any emergency or disaster period declared under the authorities listed above for any and all beneficiaries under this State Plan.

For SPA MO-20-0011, Missouri will:

- Waive state timeliness requirements for application and renewal processing;
- Extend the reasonable opportunity period for declaration of immigration status;
- Cease termination of benefits for certain changes in circumstances;
- Waive premiums, freeze scheduled premium increases, and suspend premium lock-out periods;
- Waive state specific policy requiring proof of lack of affordable insurance, and affordability look-back periods;
- Presume applicants and recipients demonstrate good cause for dropping private insurance; and,
- Cease termination of benefits in certain circumstances beginning March 1, 2020 through the duration of the State or Federal emergency declaration, whichever is later.

Effective Date: March 1, 2020
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Approval Date:
Prior Approval Date: March 21, 2019

Missouri Application for the State Children's Health Insurance Program

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

Response: The methods of establishing eligibility and continuing enrollment for SCHIP 1 and SCHIP 2 is the same as for all MO HealthNet recipients. There are several ways to obtain an application. The application is available online and can be downloaded from the DSS website at <http://www.dss.mo.gov/mhk/appl.htm>. Individuals can call a toll free number in Missouri to request that an application be mailed to them, or they may call their local FSD Office to request that an application be mailed. Applications are available at hospitals, local public health agencies, mental health facilities, and schools. Individuals may also apply by visiting their local FSD Office. Applications are available in English, Spanish, Bosnian, or Vietnamese, and translation services are available. The application is a two-page document that asks for:

- Mailing address;
- All children, parents/guardians and stepparents who live in the home;
- The Social Security Numbers (SSN) and citizenship or immigration status of those persons applying for coverage. SSNs are required only for MO HealthNet applicants. SSNs are not required for any individual who is not applying for assistance. The parent's SSN can be used to assist in verifying the family's income. However, the parent's SSN is not required. The instructions explaining whose SSNs are required are attached to the application. For simplification, FSD limits the application to one page. There is not room on one page for the instructions and the application. 42 CFR 457.340(b) does not prohibit asking for the parent's SSNs; it only prohibits a state requiring the SSN from a non-applicant.
- Information about employment, child care costs, other income, net worth, health insurance coverage, and absent parent information

Applications are processed and eligibility determinations are made within 30 days of receipt. FSD requires documentation (verification) of citizenship or immigration status and income. Applicants are notified in writing when a decision is made.

Applications are considered complete when they are signed by the claimant. If information is needed to make a determination of eligibility, the claimant is provided a written request for the information and given at least 10 days to provide it. The claimant is informed about reporting requirements and that it is against the law to obtain benefits to which they are not entitled. FSD staff provides information about income guidelines and the eligibility criteria as well as time limits for processing an application. FSD

Effective Date: 05/01/2009

Bold Italics Added Information
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Approval Date:

Prior Approval Date: 09/28/2007

Missouri Application for the State Children's Health Insurance Program

requires documentation of citizenship or immigration status for eligible children and verification of the family's income.

FSD does not have a durational requirement for residency. The eligible family members must state they are Missouri residents.

It is important to note that the State is concerned that SCHIP 1 does not "crowd out" private insurance options. The following measures will help address crowd out of private insurance options:

- There will be a six month look back period for health insurance when determining eligibility. Children whose parents' available private health insurance coverage was dropped within the last six months will have a six month waiting period under SCHIP 1. Uninsured is defined as a child (children) under age 19 who does not have creditable health insurance coverage as described at 42 CFR 457.10 and 45 CFR 146.113 that minimally provides coverage for physician's services and hospitalization. The six month look back applies. To be eligible for SCHIP 1, the child must be uninsured.
- Uninsured children are children under age 19 who do not have creditable health insurance coverage as described at 42 CFR 457.10 and 45 CFR 146.113. A child covered by health insurance at the time eligibility is determined is ineligible unless the insurance is already paid for by Missouri's Health Insurance Premium Payment Program (HIPP). If the health insurance is dropped without good cause or the child does not have a special healthcare needs exception, the child is ineligible for six months from the month coverage ended.
- The six month look back period refers to the six months prior to application. If an uninsured child lost or dropped insurance coverage in the six months prior to application, FSD explores if the reason the child is uninsured meets a good cause reason or if the child meets a special healthcare exception.
- Good cause is defined as loss of insurance coverage resulting from no action taken by the insured. Good cause reasons are:
 - A parent's or guardian's loss of employment due to factors other than voluntary termination;
 - A parent's or guardian's employment with a new employer that does not provide an option for dependent coverage;
 - Expiration of a parent's or guardian's dependent Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage period;
 - Lapse of a child's (children's) health insurance when maintained by an individual other than custodial parent or guardian;
 - Lapse of a child's (children's) health insurance when the lifetime maximum benefits under their private health insurance have been exhausted;
 - Lapse of a child's (children's) health insurance when the health insurance plan does not cover an eligible child's preexisting condition; or
 - Discontinuance of Health Insurance Premium Payment (HIPP).

Effective Date: 05/01/2009

Approval Date:

Bold Italics Added Information

Prior Approval Date: 09/28/2007

~~Strikethrough~~ Deleted Information

Missouri Application for the State Children's Health Insurance Program

- For children in families with gross income above 225% of the FPL there is a 30 day waiting period from the date of application for coverage. The 30 day waiting period does not apply to children and families with gross income below 225% FPL. These children under 225% of the FPL shall not be subject to the 30-day waiting period as long as the children meet all other qualifications for eligibility.
 - Any child identified as having special health care needs, defined as a condition which left untreated would result in the death or serious physical injury of a child, that does not have access to affordable employer-subsidized health care insurance will be exempt from the requirement to be without health care coverage for six months in order to be eligible for services, and the 30-day waiting period as long as the child meets all other qualifications for eligibility. Special healthcare needs are established based on a written statement from the child's treating physician.
- Children with special healthcare needs must still be uninsured to qualify and cannot have access to affordable health insurance. Access to affordable insurance available through employment, a group membership, or from a private company causes ineligibility. The affordability guidelines are:
 - Three percent of 150% of the FPL for a family of three, for families with a gross income of more than 150% and up to 185% FPL.
 - Four percent of 185% of the FPL for a family of three, for families with a gross income of more than 185% and up to 225% FPL.
 - Five percent of 225% of the FPL for a family of three, for families with a gross income of more than 225% but less than 300% FPL.
- Children in families with gross income above 150% of the FPL cannot have access to affordable employer sponsored or private health insurance. These children must pay a premium to be eligible (a cost sharing provision). The following is a description of the affordability test:
 - Three percent of 150% of the FPL for a family of three, for families with a gross income of more than 150% and up to 185% FPL.
 - Four percent of 185% of the FPL for a family of three, for families with a gross income of more than 185% and up to 225% FPL.
 - Five percent of 225% of the FPL for a family of three, for families with a gross income of more than 225% but less than 300% FPL.

Continuing Enrollment: Once determined eligible, the children remain eligible until FSD determines they are no longer eligible. Their coverage does not automatically end at 12 months. FSD performs annual reinvestigations to determine continued eligibility.

Families are required to report changes in circumstances (i.e., family size, income) within 10 days of when the change occurred. A reinvestigation is a re-determination of continued eligibility. The family completes an IM-1U, "Missouri MC+ Review" or a FA402, "Family Medical Assistance" reinvestigation form as part of the reinvestigation process. This form asks for names of all household members, address, income, and insurance information. It also asks about citizenship and immigration status and net

Effective Date: 05/01/2009

Bold Italics Added Information

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Approval Date:

Prior Approval Date: 09/28/2007

Missouri Application for the State Children's Health Insurance Program

worth. The family is required to respond to the questions asked on the form and submit current income verification. Upon receipt of the form, FSD will determine if additional information is needed to complete the review based on claimant's responses. If so, FSD makes a written request for the information and allows at least 10 days for a response. When a change is reported to the FSD, the Eligibility Specialist makes a determination of continued eligibility and notifies the family in writing when a decision is made. SCHIP 1 and SCHIP 2 cases are closed following a notice to the family if the family fails to complete an annual reinvestigation. A complete review of eligibility is conducted annually.

In Missouri, reinvestigation means the same as re-determination. The family is not required to re-apply. However, an annual reinvestigation is required. A significant difference between an application for MO HealthNet and a reinvestigation for MO HealthNet is the amount of documentation required. Applicants are required to submit verification of citizenship and SSN documentation for individuals who are applying. Citizenship and SSNs are not re-verified for those same individuals during a reinvestigation. A copy of the form used for MO HealthNet reinvestigations is attached.

Effective Date: 05/01/2009
Bold Italics Added Information
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Approval Date:
Prior Approval Date: 09/28/2007

Missouri Application for the State Children's Health Insurance Program

Premium Collection and Reinstatement Process: For children ages birth through age 18 with family income between 150% and 300% FPL, the premiums are detailed in the premium chart. Please see Attachment 3.

Annual Reinvestigations: The notification and hearing process followed for SCHIP 1 and SCHIP 2 is the same as for all MO HealthNet recipients. Reinvestigations are conducted annually. The reinvestigation process begins by mailing the family a two-page reinvestigation form to complete and return. The form asks the family to list:

- Mailing address;
- All children, parents/guardians and stepparents who live in the home and their Social Security Numbers, citizenship or immigration status;
- Information about employment, child care costs, other income, net worth, health insurance coverage, and absent parent information.

Eligibility continues while the reinvestigation process is being completed. If a point of ineligibility is discovered, the family is notified and given an opportunity to request a hearing. The notification and hearing process followed for SCHIP 1 and SCHIP 2 is the same as for all MO HealthNet recipients.

At the State's discretion, the following provisions related to timeliness standards and deadlines may be modified or waived in response to a disaster or emergency:

- Waiving deadlines for timely processing applications, renewals, and other related documents during the emergency period for any and all CHIP applicants or recipients; and,
- Delaying acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by a State or Federally declared disaster area such that processing the change in a timely manner is not feasible. The state will continue to act on the required changes in circumstance described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d).

At the State's discretion, the following provisions related to establishing eligibility for CHIP may be modified or waived in response to a disaster or emergency:

- Granting an extension of the reasonable opportunity period for non-citizens declaring to be in satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the ninety-day reasonable opportunity period due to the State or Federally declared disaster or public health emergency.

At the State's discretion, the following provisions related to deterring private insurance crowd-out may be modified or waived in response to a disaster or emergency:

- Waiving otherwise required proof that a CHIP applicant or recipient does not have

Effective Date: March 1, 2020

Approval Date:

Bold Italics Added Information

Prior Approval Date: 09/28/2007

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Missouri Application for the State Children's Health Insurance Program

access to other affordable insurance, including waiving the requirement to obtain quotes from other insurers;

- Presuming applicants for and recipients of CHIP have demonstrated good cause for dropping private or other employer-sponsored health insurance coverage during the disaster period; and
- Waiving lookback periods for establishing availability of private or other employer-sponsored health insurance for CHIP applicants and recipients.

Effective Date: March 1, 2020
Bold Italics Added Information
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Approval Date:
Prior Approval Date: 09/28/2007

Missouri Application for the State Children's Health Insurance Program

8.2.1 Premiums

Response: The premium amounts are calculated according to Missouri State law (the State Fiscal Year Budget and MO Revised Statute Section 208.640). Families of children in SCHIP 1 shall pay the following premium based on family size and income to be eligible to receive services:

- Enrollees with incomes above 150 percent of the FPL and up to 185 percent of the FPL shall pay four percent of the difference in income between 150 and 185 percent of the FPL.
- Enrollees with incomes above 185 percent of the FPL and up to 225 percent of the FPL shall pay:
 - four percent of the difference in income between 150 and 185 percent of the FPL;
 - plus eight percent of the amount of difference in income between 185 percent of the FPL and 225 percent of the FPL.
- Enrollees with incomes above 225 percent of the FPL and up to 300 percent of the FPL shall pay:
 - four percent of the difference in income between 150 and 185 percent of the FPL;
 - plus eight percent of the amount of difference in income between 185 percent of the FPL and 225 percent of the FPL;
 - plus 14 percent of the amount of difference in income between 225 and 300 percent of the FPL.

Effective Date: 05/01/2009

Bold Italics Added Information
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Approval Date:

Prior Approval Date: 09/28/2007

Missouri Application for the State Children's Health Insurance Program

- In no case shall the family be charged more than 5% of the family's gross income. The premium invoicing system is designed to not invoice a monthly premium in excess of 5% of the family's gross annual income divided by twelve (12).

The following table presents an example of the premium calculation.

SCHIP 1 Premium Responsibility									
Amount of Family Income	0 - 150 FPL		150 - 185 FPL		185 - 225 FPL		225 - 300 FPL	5% Income Test	
Premium Amount:	0	+	(Income at 185 - Income at 150) * .04	+	(Income at 225 - Income at 185) * .08	+	(Income at 300 - Income at 225) * .14	= Premium Responsibility	Not to exceed 5% of Family Income
Example Using July 1, 2009 FPL									
Income:	0 - \$1,354.00	+	(\$2,823 - \$2,289) = \$539 * .04 = \$21	+	(\$3,434 - \$2,823) = \$611 * .08 = \$49	+	(\$4,578 - \$3,434) = \$1,144 * .14 = \$160		
Family of 3: 150 - 185	0	+	\$21	+	\$0	+	0	= \$21	\$2,289 * .05 = \$114
Family of 3: 185 - 225	0	+	\$21	+	\$49	+	0	= \$70	\$2,823 * .05 = \$141
									\$3,434 * .05 = \$172
Family of 3: 225 - 300	0	+	\$21	+	\$49	+	\$160	= \$230	Cut back premium to \$172

At the State's discretion, provisions related to premium collection and other cost-sharing provisions may be modified or waived in response to a disaster or emergency as outlined in section 1.4, including the following:

- Freezing any scheduled increases to CHIP premiums; and,
- Waiving premiums.

Effective Date: March 1, 2020
Bold Italics Added Information
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Approval Date:
 Prior Approval Date: 09/28/2007

Missouri Application for the State Children's Health Insurance Program

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505(c))

At the State's discretion, provisions related to deadlines and timeliness may be modified or waived in response to a disaster or emergency as outlined in section 1.4, including the following:

- Allow waiver of penalty for failure to pay premiums for undue hardship. If the premium obligation is not met during the emergency period, Missouri will not discontinue coverage; and,
- The premium lock-out policy is temporarily suspended and coverage is available regardless of whether the family has paid their outstanding premium for existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

Effective Date: March 1, 2020
Bold Italics Added Information
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Approval Date:
Prior Approval Date: 09/28/2007

Missouri Application for the State Children's Health Insurance Program

Response: Premium payments are for 30 days of coverage and are paid one month in advance. A failure to pay notice is sent to recipients who have not made a payment, giving them a 30 day grace period to pay. Children with incomes between 226% and 300% of FPL have a six-month penalty applied if they fail to pay required premiums and are not eligible for coverage until the six months expire. This penalty provision does not apply to those children between 150% and 225% of FPL who may fail to pay a required premium. However, for children between 150% and 225% of FPL, coverage ends if no payment is received. Coverage for these children resumes after the next payment is received.

The Notice of Case Action provides for Hearing Rights due to failure to pay a required premium. If they request a hearing within ten days of the date of the notice, they will continue to receive benefits.

Once the recipient receives an adverse action notice they can call, write, or email to request a hearing. Once the hearing request is received, the recipient is mailed a Hearing Packet which must be completed and returned. When the Hearing Packet is returned, the Hearing Unit with the Division of Legal Services (DLS) is notified. DLS sets the time and date for the hearing. The recipient can present evidence or have someone testify on their behalf. The DLS Hearing Officer asks all the questions, and the recipient and the DLS Hearing Officer are given the opportunity to respond and present evidence. After the hearing is complete the DLS Hearing Officer makes a decision based on the evidence presented. Once the decision is complete all parties are notified and whatever action is taken.

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Bold Italics Added Information
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Approval Date:

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Missouri Application for the State Children's Health Insurance Program

9.10

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

- Planned use of funds, including -
 - Projected amount to be spent on health services;

The estimated fiscal impact for this SPA is \$3,135,616 including \$1,077,084 state share and \$2,058,532 federal funds for the period of March 1 to June 30. The fiscal impact would increase for future quarters due to additional individuals remaining eligible for Medicaid benefits. MO HealthNet assumes 1,441 individuals will remain eligible through the CHIP program each month. MO HealthNet assumes a per member per month (PMPM) cost of \$217.60 for individuals through CHIP. Please see Attachment 8, Budget.

Effective Date: March 1, 2020
Bold Italics Added Information
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Approval Date:
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