Missouri
Children's Health Insurance Program (CHIP)
and
Show Me Healthy Babies
Annual Report
2016

Prepared by the Department of Social Services
For the Missouri General Assembly

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Acknowledgement

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Introduction and Scope of the Evaluation

The Missouri Department of Social Services (DSS) is submitting this annual report to the General Assembly on Missouri's program for health care for uninsured children, the Children's Health Insurance Program (CHIP), as required by Section 208.650 of the Revised Statutes of Missouri.

The CHIP program operated as part of a Medicaid Section 1115 Healthcare Demonstration program (1115 Waiver) between September 1, 1998 and September 30, 2007. The 1115 Waiver originally expanded eligibility to uninsured children, adults leaving welfare for work, uninsured custodial parents, uninsured non-custodial parents, and uninsured women losing their Medicaid eligibility 60 days after the birth of their child.[1] Effective September 2007, Missouri's CHIP program began operating as a combination Medicaid/CHIP program, referred to as MO HealthNet for Kids.

Beginning January 1, 2016, Missouri implemented the Show Me Healthy Babies Program (SMHB) as a separate Children's Health Insurance Program (CHIP) for any low-income unborn child, as required by Section 208.662.1 of the Revised Statutes of Missouri. This program covers targeted low-income pregnant women and unborn children with household incomes up to 300% of the FPL who do not otherwise qualify for MO HealthNet. The unborn child's coverage period is from date of application to birth. For targeted low-income pregnant women, postpartum coverage begins on the day the pregnancy ends and extends through the last day of the month that includes the sixtieth (60^{th}) day after the pregnancy ends.

The SMHB legislation also requires an annual report and includes a list of possible measures. Since the program became effective in January 2016, data for this inaugural year is not significant for meaningful interpretation. Therefore, this report will provide an implementation progress update, and DSS will work towards gathering substantial data that will be used for analysis in future reports.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP through federal fiscal year (FFY) 2013. The Patient Protection and Affordable Care Act (ACA), which was enacted in 2010, continued the appropriated funding to CHIP through FFY 2015, and in 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) reauthorized CHIP for two more years, until 2017.

This report is for state fiscal year 2016 and reflects a shift in the reporting period for claims data, from calendar years to fiscal years, in order to better align enrollment, claims, and expenditures. In addition to continued funding, the ACA provided a 23% increase in the CHIP match rates for states, with a cap of 100% for FFYs 2016 through 2019. The ACA maintenance of effort requirements for the CHIP program requires states to maintain income eligibility thresholds and not impose any procedures, methodologies, or other requirements that make it more difficult for people to apply for or renew their CHIP eligibility.

In 2014, Missouri began the implementation of the Modified Adjusted Gross Income (MAGI) methodology for Medicaid and CHIP eligibility as required by the ACA. This conversion entails ending traditional income "disregards" in favor of a simplified income counting methodology rooted in gross income and closely aligned with the federal tax code. MAGI further applies a global 5% disregard to the adjusted gross income, if necessary, to safeguard eligibility determinations that could inadvertently be affected by the MAGI simplification. Income thresholds were converted to MAGI equivalents, and Medicaid income thresholds for children were adjusted to the MAGI equivalent of 133% of the Federal Poverty Level (FPL). The converted thresholds are 148% of FPL for children ages 1-18, and 196% of FPL for children aged 0-1.

[1] Service delivery to children began September 1, 1998. Service delivery for adults began February 1, 1999.

The ACA included a provision making kids ages 6-18 in families with incomes between 100% of the FPL and the MAGI equivalent of 133% of the FPL a mandatory group under the Medicaid program. Before that requirement, Missouri covered these kids under CHIP. This change resulted in many children who would have been in the CHIP non-premium category switching to Medicaid under the new, MAGI income thresholds. CMS approved continuing to use CHIP funding to cover those kids who would have been CHIP under pre-MAGI eligibility determinations. Therefore, they are included in the report, although they are in a Medicaid eligibility category, and referred to as "Medicaid/CHIP non-premium".

Missouri provides presumptive eligibility for children in families with income of up to 150% of the FPL, and for SMHB pregnant women. The table below lists the income eligibility thresholds for CHIP.

CHIP Income Eligibility

Program/ Age Group	0-110% FPL	111-148% FPL	149-150%FPL	151-196% FPL	197-300% FPL
Children 0-1	Medicaid (Non-Premium)	Medicaid (Non-Premium)	Medicaid (Non-Premium)	Medicaid (Non-Premium)	CHIP (Premium)
Children 1- 5	Medicaid (Non-Premium)	Medicaid (Non-Premium)	CHIP (Non-Premium)	CHIP (Premium)	CHIP (Premium)
Children 6-18	Medicaid (Non-Premium)	Medicaid/CHIP (Non-Premium)	CHIP (Non-Premium)	CHIP (Premium)	CHIP (Premium)
SMHB	SMHB (Non-Premium)	SMHB (Non-Premium)	SHMB (Non-Premium)	SHMB (Non-Premium)	SHMB (Non-Premium)

Beginning in September 2005, copays were eliminated in lieu of graduated premiums for all families with incomes greater than 150% FPL, with the exception that infants under one are not subject to premiums unless their family income exceeds 196% FPL. Premiums are based on income and effective July 1, 2015, ranged from $14 per month for a family size of one with income more than 150% FPL to $305 per month for a family size of six. Premium rates are adjusted annually, in July of each year, and exist in three different bands: (i) 151-185% FPL, (ii) 186-225%, and (iii) 226-300% FPL. In no case shall the family be charged more than five percent of the family's gross income, and the premium invoicing system is designed to not invoice a monthly premium in excess of five percent of the family's gross annual income divided by twelve (12).[2]

Missouri allows for a 30-day grace period for non-payment of premiums, but for families with income over 225% FPL, there is a lockout period of ninety (90) days after disenrollment due to non-payment of premiums after the grace period. For these families to re-enroll, repayment of outstanding premiums is required even after the ninety (90) day lockout period has concluded.

CHIP Strategic Goals

- Reduce the number of children in Missouri without health insurance coverage.
- Increase access to health care.
- Increase the number of children in Missouri who have access to a regular source of healthcare coverage.
- Improve the health of Missouri's medically uninsured children through the use of preventive care.

[2] For the full premium chart, see Appendix III.

Study Questions

The report focuses on the following three questions, which are outlined in the original legislative mandate to evaluate the CHIP program. A fourth question has been added to provide a progress report on the implementation of the Show Me Healthy Babies Program.

Study Question 1

Has CHIP improved the health of Missouri's children and families?

Response includes:

- The number of children participating in the program in each income category.
- The effect of the program on the number of children covered by private insurers.
- The effect of the program on medical facilities, particularly emergency rooms (ERs).
- The overall effect of the program on the health care of Missouri residents.
- The overall cost of the program to the State of Missouri.
- The methodology used to determine availability for the purpose of enrollment, as established by rule.

Study Question 2

What is the impact of CHIP on providing a comprehensive array of community-based wrap-around services for seriously emotionally disturbed children and children affected by substance abuse?

Study Question 3

What is the effect of CHIP on the number of children covered by private insurers? Did the expansion of health care coverage to children whose gross family income is above 185%FPL have any negative effect on these numbers?

Study Question 4

Show Me Healthy Babies (SMHB) Implementation Progress Report

Terminology

The following terminology is used throughout the report:

- MO HealthNet or Medicaid refers to the Title XIX State Plan Medicaid population.
- CHIP refers to the targeted low-income expansion program for children.
- SMHB refers to the Show Me Healthy Babies Program for targeted low-income pregnant women and unborn children.

Data Sources and Approach

The report uses previously aggregated, readily available data from the State of Missouri and the following sources:

- Health Status Indicator Rates — Department of Health and Senior Services (DHSS), Community Health Information Management and Epidemiology (CHIME), calendar year (CY) 2014.
- U.S. Census Data, 2000-2014.
- Claims data from FY 2016.
- Eligibility data FY 2016.
- Monthly Management Report, Table 1 — Department of Social Services (DSS), Fiscal Year 2016.
- Journal articles and health publications produced by the Federal Government and national health policy researchers (credited in the footnotes).

The most recent data available from these sources was used in compiling this year's report. To facilitate the comparison of longitudinal data across this year's report and previous years' reports, the same data sources have been used where possible.

Study Question 1

Has CHIP improved the health of Missouri's children and families?

1. What is the number of children participating in the program in each income category?

For FY 2016, CHIP program enrollment ranged from under 60,000 to just over 70,000 participants (See table below).[3]

CHIP Participants by Eligibility Category

Month	Year	Medicaid/CHIP (non-Premium)	CHIP (non-premium)	CHIP (premium)	SMHB	Total
July	2015	25,531	10,337	24,407		60,275
August	2015	26,951	8,222	24,218		59,391
September	2015	28,019	5,355	23,903		57,277
October	2015	31,869	3,050	23,820		58,739
November	2015	32,570	2,604	23,651		58,825
December	2015	33,660	1,726	23,848		59,234
January	2016	35,701	1,389	24,718	212	62,020
February	2016	36,087	1,137	25,142	445	62,811
March	2016	36,288	848	25,390	639	63,165
April	2016	44,358	667	25,340	828	71,193
May	2016	44,631	635	25,326	979	71,571
June	2016	44,571	657	24,970	1,009	71,207

2. What is the effect of the CHIP program on the number of children covered by private insurers?

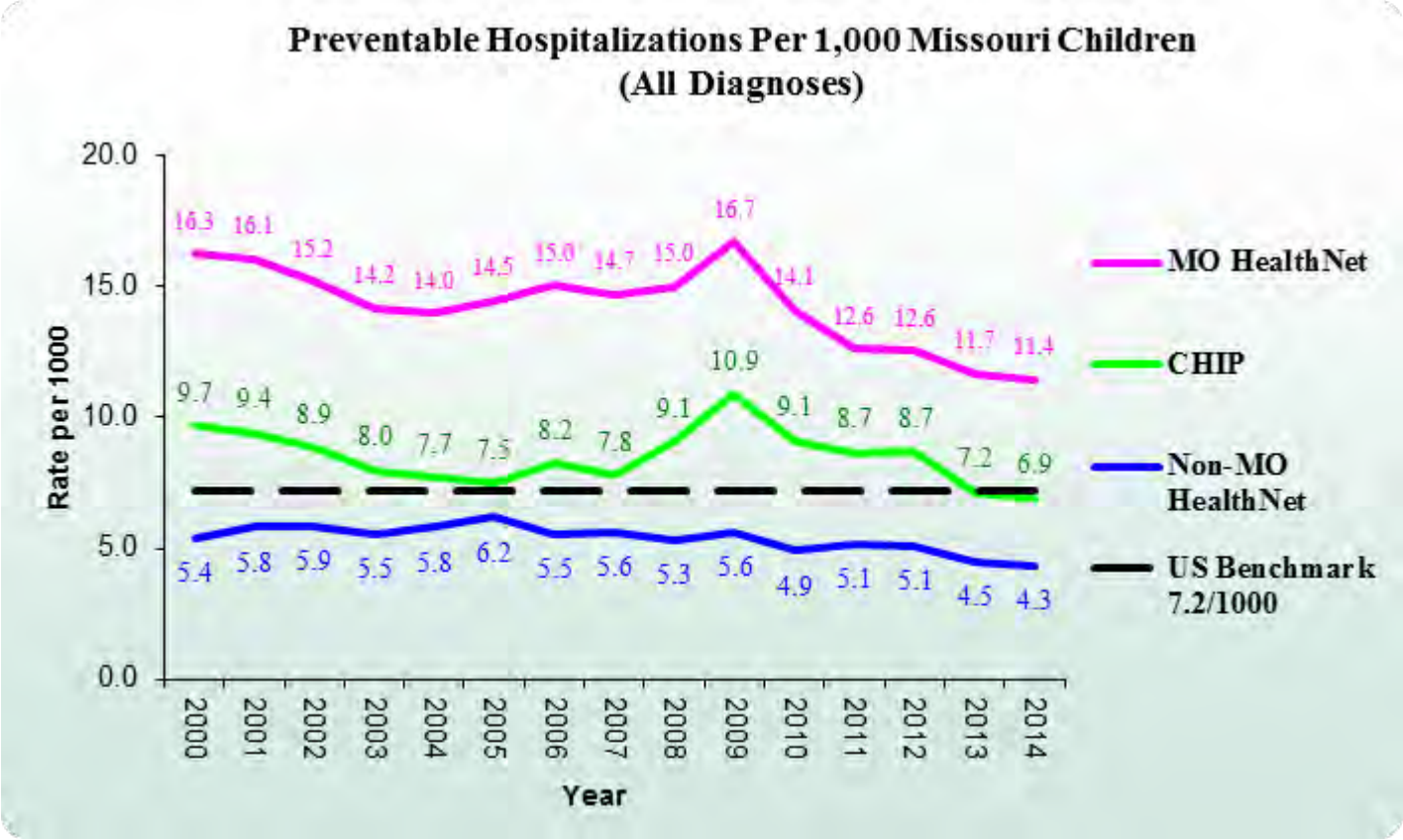
Over the last five years, the Missouri rate of children's private insurance (including employer sponsored insurance (ESI) and self-pay insurance) has remained fairly stable. Of note, and as demonstrated in the charts found on page 19, Missouri's uninsured population has decreased from 11.5% in 2011 to 5.7% in 2015, consistent with national trends. Missouri's rate of public insurance coverage for children (Medicaid and CHIP) remains below the national average and is almost the same in 2015 as in 2013. This means that it is highly unlikely that crowd out (the substitution of publicly funded coverage for existing private coverage) is occurring, as there has not been a major growth in public insurance coverage, even with the recession and the watermark effect of marketplace enrollment. Question three explores this question in greater detail in this report.

[3] Note: Enrollment numbers are unique members in each income category. Because of the MAGI conversion, the enrollment counts for the Medicaid/CHIP (non-premium) and SMHB categories were extracted from eligibility and enrollment data. The CHIP (non-premium) and CHIP premium enrollment were provided by the Monthly Management Report, Table 13, for fiscal year 2016. The SMHB enrollment data were provided to MHD by an IBM generated COGNOS report.

3. What is the effect of the CHIP program on medical facilities, particularly emergency rooms?[4]

Preventable Hospitalizations

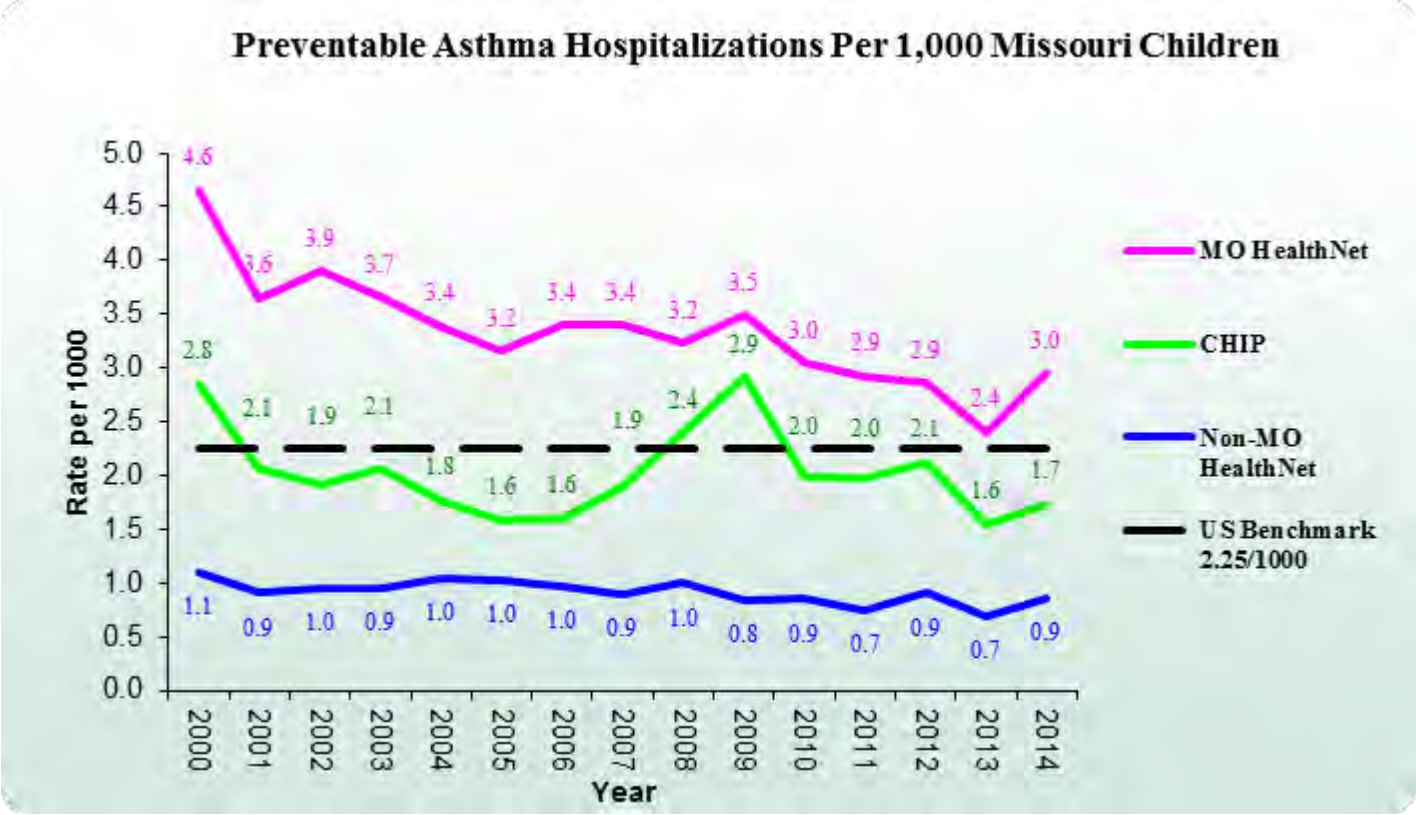
- From 2000 to 2014, preventable hospitalizations for the CHIP population decreased by 28.9%. During this time, preventable hospitalizations for the MO HealthNet (Medicaid children) population decreased by 30.1% while the preventable hospitalizations for the non-MO HealthNet group decreased by 20.4%
- In 2014, the CHIP group's rate of preventable hospitalizations per 1,000 children was 6.9, below the national benchmark of 7.2 per 1,000.



[4] For this question, hospital data from CY 2014 was used, which was the most recent set of data available from DSS.

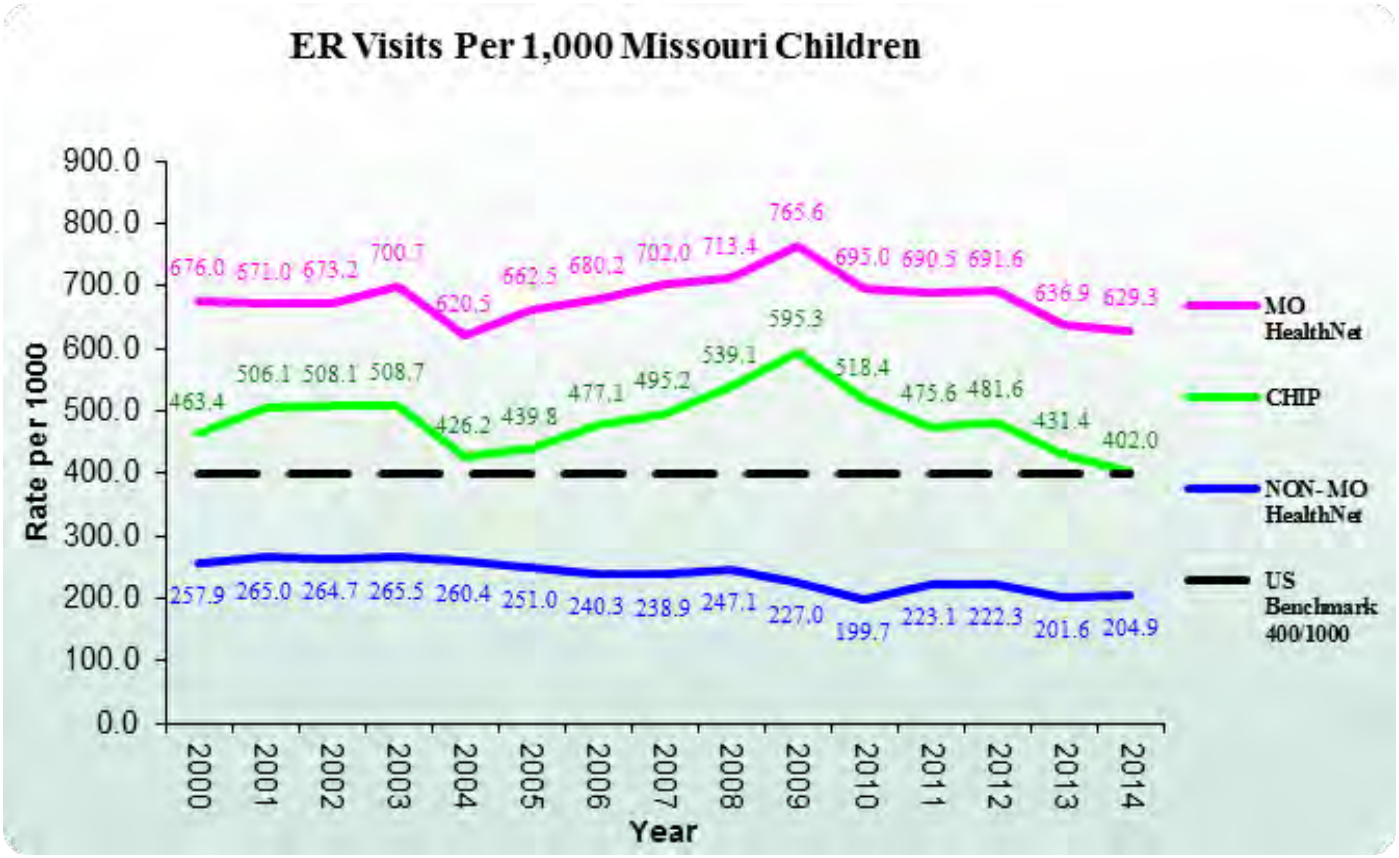
Preventable Asthma Hospitalizations

- From 2000 to 2014, preventable hospitalizations due to asthma for the CHIP population decreased by 39%. During this time, preventable hospitalizations due to asthma for the MO HealthNet (Medicaid children) population decreased by 34.8% while the preventable asthma hospitalizations for the non-MO HealthNet group decreased by 18.2%.
- In 2014, the CHIP group's rate of 1.7 preventable asthma hospitalizations per 1,000 children was 24% lower than the national benchmark rate of 2.25 preventable asthma hospitalizations.



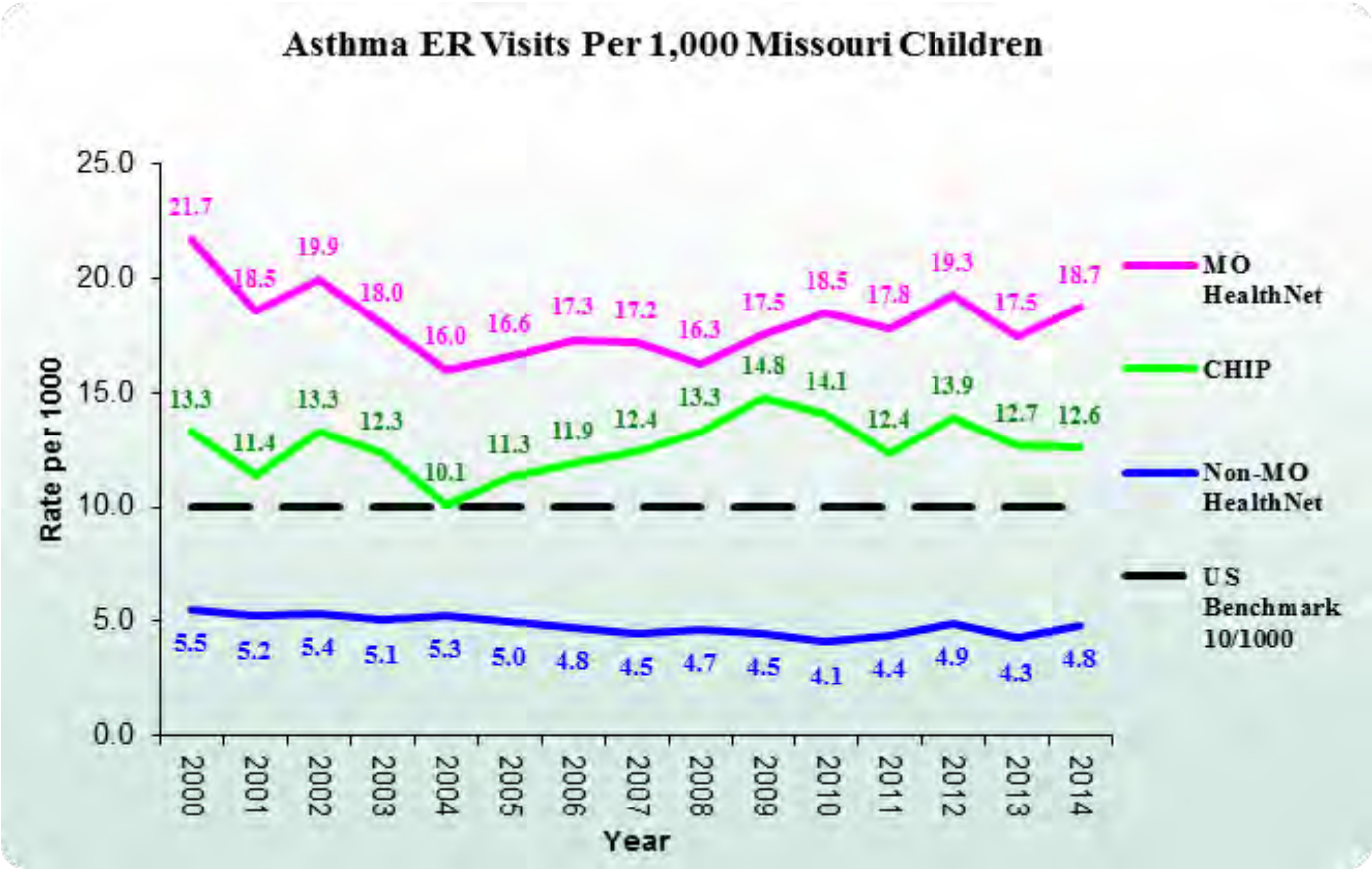
Emergency Room (ER) Visits

- From 2000 to 2014, ER visits for the CHIP population decreased by 13.2%. During this time, ER visits for the MO HealthNet (Medicaid children) population decreased by 6.9% while the ER visits for the non-MO HealthNet group decreased by 20.5%.
- In 2014, the CHIP group's rate of 402 ER visits per 1,000 children mirrored the national benchmark rate of 400 ER visits.



Asthma ER Visits

- From 2000 to 2014, asthma ER visits for the CHIP population decreased by 5.4%. During this time, asthma ER visits for the MO HealthNet (Medicaid children) population decreased by 13.8%, while the asthma ER visits for the non-MO HealthNet group decreased by 12.7%
- In 2014, the CHIP group rate of 12.6 asthma ER visits per 1,000 children was 26% higher than the national benchmark rate of 10 Asthma ER visits per 1,000 children.



Preventable Hospitalizations Summary

The data shows improvement in three of the four indicators for the CHIP population when comparing 2013 to 2014. Rates of preventable hospitalizations, general and asthma-related, are equal to or below national benchmarks and equal to or below their best rates since 2000, and ER visits for CHIP kids is essentially at the benchmark for the first time.

Rates of asthma-related ER visits decreased between study years 2013 and 2014. However, the measure is still above the national benchmark. Children with Medicaid and CHIP are more likely to seek care through the ER than both uninsured children and children with private coverage. In a controlled study conducted in 2008, 28% of Medicaid and CHIP children visited the ER at least once, as compared to 18% of children with private coverage and 15% of uninsured children. Medicaid and CHIP children were also more likely to have had multiple visits to the ER.

Barriers to access to primary care and more specifically the opportunity to obtain primary care after business hours remain key determinants in this trend for CHIP and Medicaid children[5].

A summary of the indicators from 2014 is presented in the following table. Detailed data by region and by year is included as Appendix I to this report. In 2017, MO HealthNet will implement an asthma education and in-home environmental assessment program for youth with uncontrolled asthma. This program is anticipated to reduce ER utilization among the targeted population.

Summary of 2014 Indicators for Missouri Children Under 19 Per 1,000 Children

	CHIP	MO HealthNet (Medicaid)	Non-MO HealthNet (Non-Medicaid)	National Benchmark
Preventable Hospitalizations	**6.9**	**11.4**	**4.3**	**7.2**
Preventable Asthma Hospitalizations	**1.7**	**3.0**	**0.9**	**2.3**
ER Visits	**402.0**	**629.3**	**204.9**	**400.0**
Asthma ER Visits	**12.6**	**18.7**	**4.8**	**10.0**

Data Sources: DHSS; Benchmark: Kozak, Hall and Owings (preventable hospitalizations), Healthy People 2000 (preventable asthma hospitalizations), CDC's Health, United States, 2005 (ER visits), CDC, NCHS Health E-Stats (ER Asthma Visits)

4. What is the overall effect of the CHIP program on the health care of Missouri residents?

Studies analyzing the impact of health care coverage on children's health show that children who have insurance have better health outcomes and higher academic success rates than uninsured children. Though the studies are not specific to the State of Missouri, they show the benefits of being enrolled in the CHIP program.

A 2016 report published by the Kaiser Family Foundation demonstrated the success of the CHIP program beyond improved health outcomes; research delineated a correlation between CHIP enrollment and improvement in school attendance, performance, and motivation to pursue higher education[6].

Further, a 2014 report of compiled research published by the Kaiser Family Foundation found a large and consistent body of evidence that reiterates the correlation of enrollment in Medicaid or CHIP and better health outcomes including: children are more likely to have a usual source of care, visits to physicians and dentists, and use of preventive care. In addition, these children are less likely to have unmet health care needs for physician services, prescription drugs, dental and specialty, as well as hospital care. In nine of ten studies cited in the Congressionally-mandated evaluation of CHIP, rates of unmet need were reduced by 50% or more as compared to before CHIP. Evidence from some states further indicates that increased access was accompanied by reduced emergency department use.[7]

A 2012 report published by the Urban Institute for the Medicaid and CHIP Payment and Access Commission (MACPAC)[8] found that for almost every measure of access to health care nationwide, children in CHIP had

[5] The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us? The Kaiser Family Foundation, July 2014
[6] Children's Health Coverage: The Role of Medicaid and CHIP and Issues for the Future. The Kaiser Family Foundation, March 2016
[7] *Ibid*.
[8] Urban Institute, National Findings on Access to Health Care and Service Use for Children Enrolled in Medicaid or CHIP, Kenney and Coyer, March 2012.

substantially better access to care than uninsured children and almost equal access to children with Employee Sponsored Insurance (ESI). Compared to uninsured children, children on CHIP were more likely to have a usual source of care, had greater access to specialists, and were less likely to have unmet needs due to costs or experience delays in receiving care. The experience of children in CHIP was similar to that of children in ESI, once adjusted for demographics, with similarly high rates of a usual source of care in addition to being less likely to have delayed medical care due to costs.

As reported by MACPAC in their March 2014 report[9], the factors that affect health care have become more complex, in particular for families who may qualify at times for marketplace coverage. While eligible, there could be barriers to the cost of marketplace premiums or, more often, the need to "churn" between programs as various points of the family financial cycle are experienced. These social determinants, along with economic recovery instability, have the potential to affect not just enrollment numbers, but the health and wellness of beneficiaries.

5. What is the overall cost of the CHIP program to Missouri?[10]

The CHIP program is funded through Federal and State appropriations (both through general State revenue and other State agency dollars).[11] The Federal/State share data is not yet available for expenditures paid for the Medicaid/CHIP non-Premium group; the total for that population is included in the table below. SMHB expenditures have been included in this year's report, but it should be noted that the program's implementation date was January 1, 2016 — halfway through the fiscal year.

CHIP FY 2016 Expenditures				
State Funds	**CHIP**	**SMHB**	**Medicaid/CHIP prior to ACA**	**Total**
General Revenue	$7,753,338	$737,968		
Other Funds*	$7,703,116			
Federal Funds	$56,169,401	$1,670,240		
Total	**$71,625,855**	**$2,408,208**	**$87,914,254**	**$161,948,317**

**Other Funds include FRA, Pharmacy Rebate, HIF, Premium, PFRA, and IGT.*

6. What is the methodology used to determine availability for the purpose of enrollment?

13 CSR 70-4.080, State Children's Health Insurance Program, is the Missouri rule that establishes the methodology to determine eligibility for enrollment.[12]

The eligibility provisions for families with gross income of more than 150% FPL are:

- Parents/guardians of uninsured children must certify the child does not have access to affordable ESI or other affordable available coverage.

[9] Medicaid and CHIP Payment and Access Commission (MACPAC) Report to the Congress on Medicaid and CHIP, March 2014.
[10] For this question, financial data from FY 2016 was used.
[11] Other sources of state funding include the Pharmacy Rebate Fund, FRA Fund, Health Initiative Fund, Life Sciences Research Fund, the Premium Fund, etc.
[12] This regulation can be found online at http://s1.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c70-4.pdf

- Infants under one year with gross incomes of less than 196% FPL are exempt from premiums.
- Children in families with gross incomes of more than 150% FPL but up to 225% FPL are eligible for coverage once a premium has been received. Eligibility for the program may begin at the beginning of the month; however, coverage cannot begin until the premium has been received.
- Children in families with gross incomes of more than 226% FPL and up to 300% FPL are eligible for coverage 30 calendar days after the receipt of the application, or when the premium is received, whichever is later.
    - Any child identified as having special health care needs — defined as a condition that, left untreated, would result in the death or serious physical injury of a child — who does not have access to affordable ESI will be exempt from the 30-day waiting period in order to be eligible for services, as long as the child meets all other qualifications for eligibility. Special health care needs are established based on a written statement from the child's treating physician.
- The 30 calendar day delay is not applicable to children already participating in the program when a parent's income changes.
- Pregnant women not otherwise eligible with gross incomes of less than 300% are eligible for coverage under the SMHB program. SMHB participants can be determined presumptively eligible, and have no cost-sharing requirements.
- Total aggregate premiums cannot exceed five percent of the family's gross income for a 12-month period.
- Premiums must be paid prior to delivery of service.
- Premiums will be updated annually and take effect on July 1 of each calendar year.

Study Question 2[13]

What is the impact of CHIP on providing a comprehensive array of community-based wrap-around services for seriously emotionally disturbed (SED) children and children affected by substance abuse?

Wrap-around services are a class of treatment and support services provided to a SED child and/or the child's family with the intent of facilitating the child's functioning and transition towards a better mental health state. Wrap-around services include family support services, case management, respite care, targeted case management, community support services, transportation support, social and recreational support, basic needs support, and clinical/medical support.

The Department of Mental Health (DMH) and the MO HealthNet Division have developed joint protocols and guidelines for the provision of wrap-around services. DMH provides the funding for the services (either full funding or the State's match). DMH also coordinates and oversees the delivery of these services.

Methodology for Data Analysis

Comparisons of utilization of wrap-around services across service delivery systems (i.e., fee-for-service (FFS) versus managed care) are focused on evaluating whether Managed Care Organization (MCO) enrollment impacts

[13] For this question, claims and enrollment data from FY 2015 was used.

which wrap-around services are provided and in what manner they are provided. DSS and DMH data on CHIP program eligibility, MCO enrollment, and wrap-around service utilization beginning July 1, 2015 and ending June 30, 2016, were used for the purpose of this analysis. In previous reports, data from the preceding calendar year was used; for this report and for future reports, most recent fiscal year data was and will be used to align with the enrollment data. Since outstanding claims (run-out) exist on services provided during the FY 2016 fiscal year that are not included in this data, service counts may be lower in this report; however, in future reports the previous year's run-out will be included, which should compensate for comparisons in the future.

There were 390 unique children in the CHIP program population who received wrap-around services during the study period. For analysis, the group was further divided into 145 FFS participants and 209 MCO participants; 36 of these received services through both delivery methods at different times during the year and are counted in both categories.

The MCOs are not required by contract to provide wrap-around services. However, the MCOs often do provide these wrap-around services when it is cost effective as a diversion from more intensive levels of care. The average child receiving FFS wrap-around services received slightly more services than the average child receiving MCO wrap-around services, as illustrated in Chart A below. Overall, FFS children received fewer wrap-around services in FY 2016 than in CY 2015 however, MCO children received more services. Chart B, on the subsequent page, shows how the mix of services differed between the FFS and MCO populations. For example, 25.7% of the wrap-around services provided to the FFS population consisted of case management services, while these services represented only 7.8% of the wrap-around services provided to the MCO population.

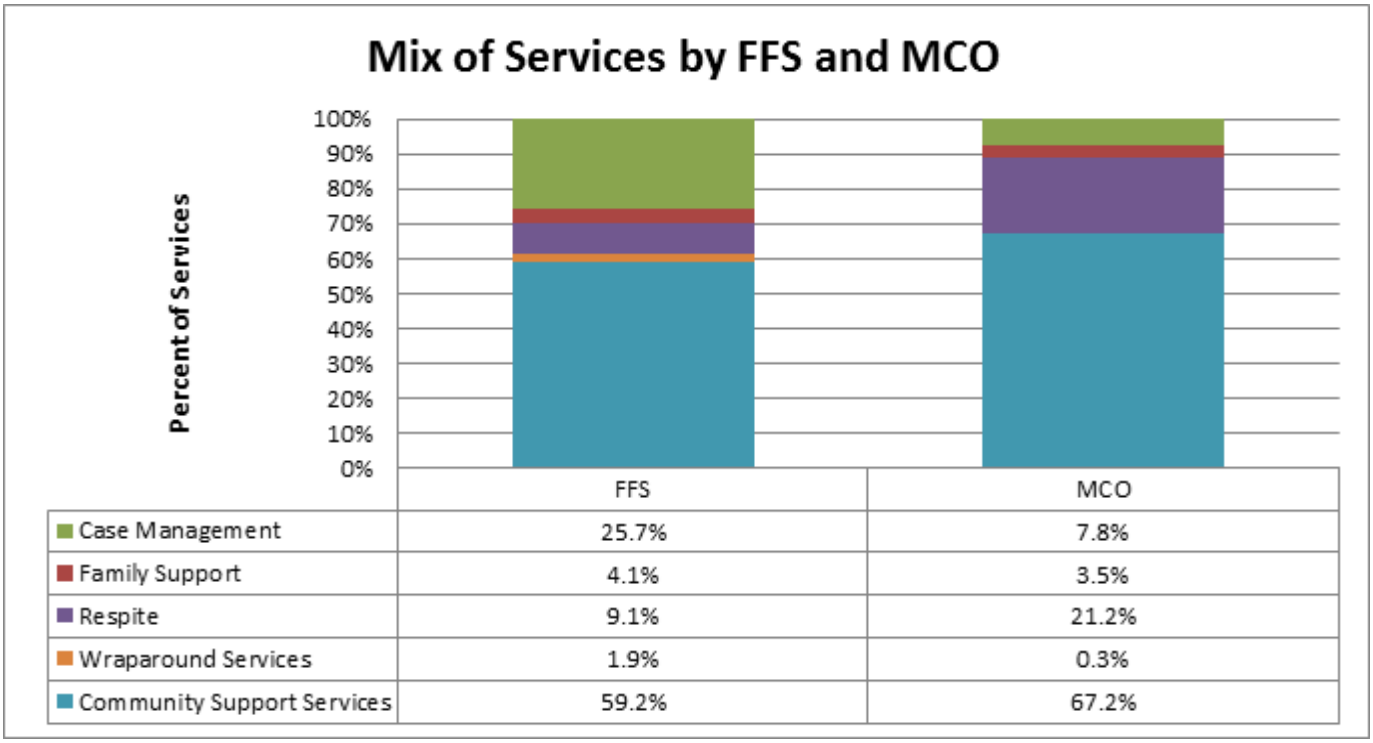
The following charts show utilization rates of wrap-around services by type in FY 2016.

CHART A

Quantity of Wrap-around Services (Units)

Wraparound Services	Family Support	Other Case Management	Respite	Targeted Case Management	Wraparound Services	Community Support Services	Grand Total
Quantity of Services FFS	135	623	298	218	63	1937	3,274
Quantity of Services: MCO	150	335	906	1	13	2878	4,283
Services per Child: FFS	0.7	3.4	1.6	1.2	0.3	10.7	18.1
Services per Child: MCO	0.6	1.4	3.7	0	0.1	11.7	17.5

CHART B



	FFS	MCO
Case Management	25.7%	7.8%
Family Support	4.1%	3.5%
Respite	9.1%	21.2%
Wraparound Services	1.9%	0.3%
Community Support Services	59.2%	67.2%

These statistics cannot be used on their own to determine the quality of wrap-around services received by each population. There may be variances in each population that account for the different types of services. For example, the FFS population is primarily rural and the MCO population is predominantly urban. As found in previous years' studies, both delivery systems are providing similar numbers of community support services and have shifted away from targeted case management.

Study Question 3

What is the effect of CHIP on the number of children covered by private insurers?

The shift from private health insurance coverage to public coverage, known as crowd out, is relatively difficult to measure. Generally, crowd out refers to the substitution of publicly funded coverage for existing private coverage. Individuals may choose to forgo coverage available from their employer or in the individual market because publicly funded coverage is more affordable or more comprehensive. Alternatively, employers may choose to drop coverage for their employees once public coverage becomes available for them.

Crowd out is difficult to identify because not all substitution of public for private coverage constitutes crowd out. A crowd out situation arises only if the actions taken — people substituting public for private coverage, or employers changing or terminating their insurance offerings — would not have occurred in the absence of the public program. If people would otherwise have become uninsured, enrolling in a public program does not constitute crowd out.[14]

[14] Davidson, G., L. A. Blewett, & K. T. Call (June 2004). *Public Program crowd-out of private coverage: What are the issues?* The Robert Wood Johnson Foundation: Research Synthesis Report No. 5.

The most common definition of crowd out compares the reduction in the share of the population with private coverage to the increase in the share of the population with public coverage due to the expansion. Researchers using this definition attempt to estimate the changes due solely to the expanded eligibility over the period of years included in the study.

A congressional report on CHIP by Mathematica Policy Research from December 2011[15] concludes that crowd out in the CHIP program nationwide is less than expected:

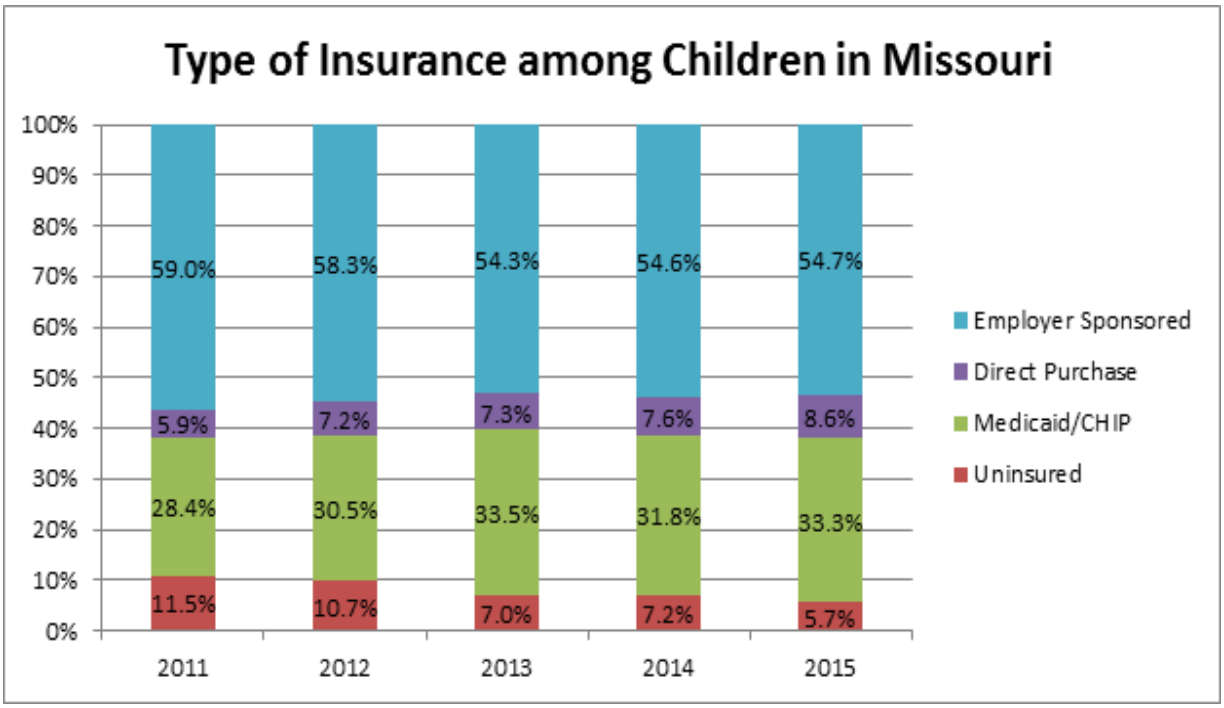
> *"While studies differ in their methods and data sources, existing evidence indicates that some level of crowd out is unavoidable but the magnitude of substitution is lower than many expected and in general concerns about CHIP substituting for private coverage have lessened over time…Estimates of substitution rates from population-based studies range from none to as much as 60 percent of the increase in public coverage from CHIP coming from reductions in private coverage (Dubay and Kenney 2009; Gruber and Simon 2008; Lee et al. 2008; Bansak and Raphael 2007; Davidoff et al. 2005; Hudson et al. 2005; LoSasso and Buchmueller 2004; Cunningham et al. 2002). More recent studies using longitudinal data sources and improved methods for handling cases with both public and private coverage…estimate substitution rates ranging from 7 to 30 percent."*

Since 2000, there has been a redistribution of insurance coverage by type in both Missouri and the nation as a whole. Nationally over this period there has been an overall decline in ESI, but the ESI rate remained stable from 2013 through 2015. Likewise in Missouri from 2013 to 2015, ESI rates for children remained stable with a very slight increase; the 2014 rate (55%) is notably lower than the 2010 rate (59%). In the last three years, direct purchase of insurance for children both nationally and in Missouri has increased from 6.6% to 7.2% nationally, and from 7.3% to 8.6% in Missouri. This may be reflective of the individual mandate included in the ACA. During this three year time period, the combined U.S. census data for Medicaid and CHIP in Missouri shows Medicaid/CHIP coverage remaining stable. However, the national figure has continued to rise, from 37.9% to 39.7%. Finally, the rate of uninsured children in the State of Missouri continued to improve as it decreased to 5.7% in 2015 from 7.2% in 2014.

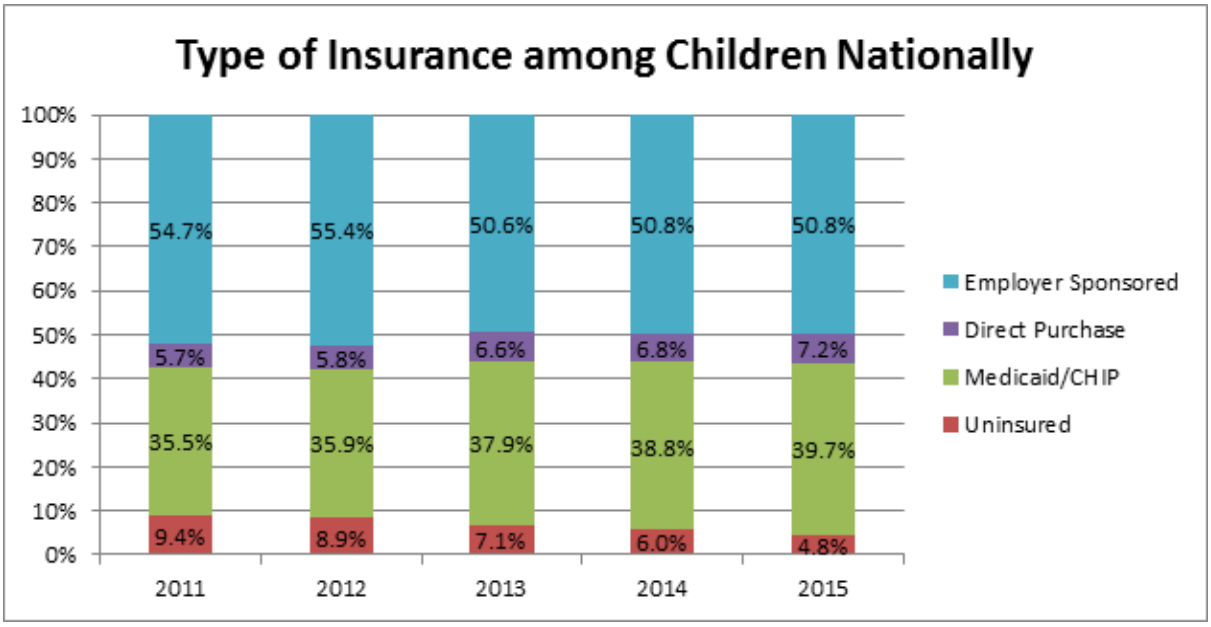
This data suggests that the expansion of the CHIP program has had little to no impact on the number of children covered by private insurance, and in fact, Missouri is outpacing the rest of the nation in maintaining private health insurance rates, both in overall percentage and in trend in the last five years. The next two charts illustrate these five-year trends.

[15] Mathematica Policy Research (December 2011). *Children's Health Insurance Program: An Evaluation (1997-2010).*

Missouri Children Compared to U.S. Children 2011-2015[16]



Type of Insurance among Children Nationally: 2011-2015



[16] Data is based on the Census Bureau's March 2015 Current Population Survey (CPS: Annual Social and Economic Supplements) and American Community Survey (ACS), which combine the Medicaid and CHIP programs. Columns do not add up to 100% in this data source, as people can be in more than one category. 2014 is the most recent year's data available for this measure. Children are aged 0-18. http://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2015.html

Much of the research on crowd out in children's coverage historically finds that it is a significant factor only when states expand coverage further up the income scale, since children in moderate income families are more likely to have access to affordable employer-based coverage than their lower-income counterparts, which could be complicated by marketplace options in some states. Using a broad definition of crowd out, the Congressional Budget Office concludes that between 25% and 50% of children enrolled in CHIP — which covers children with incomes too high to qualify for Medicaid — previously had private health insurance.[17]

A recent Center for Medicare and Medicaid Services (CMS) report by the Ohio State University College of Public Health[18] suggests the opposite; that the higher the state's eligibility threshold, the lower the crowd out around the eligibility threshold. The report estimated threshold crowd out levels for all 50 states and found no evidence of threshold crowd out in Missouri, or in any of the other 18 states with an eligibility threshold of 300% FPL. The data also suggests much lower crowd out overall than previous studies, with an overall State range of 0% to 12%. Overall crowd out in Missouri was found to be 2.35 percent. The report concludes:

> *"The relatively small crowd out at all income levels suggests that the discourse on children's health insurance programs should shift away from crowd-out towards the merits of public programs. Arguments for and against public children's health insurance programs should be based on benefits of publicly insuring children who otherwise would be uninsured, not on whether previously insured children drop private insurance and move to the public's payrolls."*

The comparison of Missouri's population by insurance type and status to the national trends over the last five years (above) is a strong indicator that the policies in Missouri designed to minimize crowd out, like the requirement for six prior months of no coverage before enrolling in CHIP, have been successful. This should be carefully monitored, as the State elected to eliminate the six-month waiting period in September of 2014, to see if indications of crowd out appear in future reports.

[17] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[18] Medicare and Medicaid Research Review (2013, Volume 3, Number 3). *State Variability in Children's Medicaid/CHIP Crowd-Out Estimates.*

Study Question 4

Show Me Healthy Babies Implementation Progress Report

Per the authority of Title XXI of the federal Social Security Act, the State Children's Health Insurance Program, as amended and of 42 CFR 457.1, during the 2014 legislative session, the General Assembly passed and Governor Nixon signed SB 716 and SB 754 authorizing the Show Me Healthy Babies Program (SMHB), subject to appropriation. The SMHB program was funded in the state fiscal year 2016 budget. The SMHB program became effective on January 1, 2016. This program covers targeted low-income pregnant women and unborn children with household incomes up to 300% of the FPL who do not otherwise qualify for MO HealthNet. The unborn child's coverage period is from date of application to birth. For targeted low-income pregnant women, postpartum coverage begins on the day the pregnancy ends and extends through the last day of the month that includes the sixtieth (60^{th}) day after the pregnancy ends. Coverage for the child shall continue for up to one year after birth.

The SMHB legislation requires an annual report and includes a list of possible measures. Since the program became effective in January 2016, data for this year is not significant for meaningful interpretation. Therefore, this report provides an implementation progress update while DSS works towards gathering substantial data that will be used for analysis in future reports.

The Program provides pregnant women with access to prenatal care and an opportunity to connect individuals to longer-term coverage options.

The SMHB eligibility requirements are as follows:

1. Pregnant
2. Resident
3. Is not eligible for any other MO HealthNet program
    - Except Uninsured Women's Health Services, Extended Women's Health Services, and Gateway To Better Health
4. Household income up to 300% of the FPL
    - An unborn child, whose mother was denied MO HealthNet for Pregnant Women (MPW) for excessive income, must have income that is between 196% - 300% of FPL
    - An unborn child, whose mother was denied MPW for citizenship, must have income not to exceed 300% of FPL
5. No access to employer insurance or affordable private insurance which includes maternity benefits (prenatal, labor and delivery, and post-partum coverage)

Questions analyzed in this report are the following:

- How many births have occurred since the inception of the Show Me Healthy Babies program?
- How many beneficiaries are enrolled on a month to month basis for the first six (6) months?
- What are the costs incurred in the Show Me Healthy Babies program since its inception?[19]

[19] See Expenditures Chart, p 14.

Future reports may measure additional factors such as birth rates, ER utilization among pregnant women, percentage of women enrolled in SMHB, percentage of prenatal care visits for SMHB recipients, or other measures, to produce effective comparisons and establish trends among the SMHB population. The newly enrolled SMHB population will be compared to subsequent years of SMHB recipient outcomes to establish baselines and study questions once the respective data becomes available. Based on the available data, wrap-around services will also be included in future reports.

The following table shows Show Me Healthy Babies Program Enrollment by month and cumulatively.

SMHB Enrollment by Month[20]

Newly Enrolled Participants by Month				
Month	**Year**	**SMHB Women**	**SHMHB Infants**	**Total New**
July	2015			
August	2015			
September	2015			
October	2015			
November	2015			
December	2015			
January	2016	196	16	212
February	2016	210	29	239
March	2016	164	67	231
April	2016	157	59	216
May	2016	140	60	200
June	2016	140	91	231
Total Current Enrollment				
Ending June 30	**2016**	**698**	**311**	**1,009**

Three hundred and eleven (311) babies were born to SMHB pregnant women in the first six months of implementation of this program. These children became CHIP/Medicaid participants after birth. Of the women who gave birth, an average of 30% began coverage in the 2nd trimester, and 70% began coverage in the 3rd trimester. Future reports will analyze this further.

[20] Data provided to MHD from an IMB generated COGNOS report.

APPENDIX I

Hospitalization and ER Utilization Rates by Payer/Program (2000-2014)

Review period: January 1, 2014 — December 31, 2014
Data source: Missouri Department of Health and Senior Services (DHSS)

Asthma Hospitalizations Age < 19

Benchmark = 2.25/1,000 pop.
Healthy People 2000

Rates per 1000 population

Cal. Year	Population	*Eastern*	*Central*	*Western*	*Other*	State
2000	CHIP	5.2	1.8	3.9	1.7	**2.8**
2001	CHIP	3.0	1.8	2.3	1.3	**2.1**
2002	CHIP	2.5	1.8	2.9	1.2	**1.9**
2003	CHIP	2.9	1.3	2.7	1.6	**2.1**
2004	CHIP	2.9	1.2	1.6	1.2	**1.8**
2005	CHIP	2.6	0.8	1.6	1.0	**1.6**
2006	CHIP	2.3	1.0	2.3	0.9	**1.6**
2007	CHIP	3.5	0.7	1.9	0.8	**1.9**
2008	CHIP	4.6	1.4	2.1	1.2	**2.4**
2009	CHIP	4.8	1.8	3.2	1.6	**2.9**
2010	CHIP	3.6	1.0	1.6	1.2	**2.0**
2011	CHIP	4.0	0.5	1.6	1.0	**2.0**
2012	CHIP	4.0	0.7	2.0	1.2	**2.1**
2013	CHIP	2.1	0.5	2.4	0.9	**1.6**
2014	CHIP	2.9	0.8	1.7	1.1	**1.7**
Change from 2000 to 2014		**-45.0%**	**-53.4%**	**-55.9%**	**-34.2%**	**-39.0%**
2000	Non-MO HealthNet	1.3	0.9	1.1	0.9	**1.1**
2001	Non-MO HealthNet	1.1	0.7	1.0	0.7	**0.9**
2002	Non-MO HealthNet	1.2	0.8	0.8	0.8	**1.0**
2003	Non-MO HealthNet	1.1	0.8	1.0	0.7	**0.9**
2004	Non-MO HealthNet	1.3	1.1	0.8	0.8	**1.0**
2005	Non-MO HealthNet	1.3	0.6	1.0	0.8	**1.0**
2006	Non-MO HealthNet	1.2	0.8	0.9	0.7	**1.0**
2007	Non-MO HealthNet	1.2	0.6	0.9	0.7	**0.9**
2008	Non-MO HealthNet	1.4	0.7	0.7	0.7	**1.0**
2009	Non-MO HealthNet	1.1	0.7	0.6	0.6	**0.8**
2010	Non-MO HealthNet	1.2	0.5	0.6	0.6	**0.9**
2011	Non-MO HealthNet	1.1	0.4	0.6	0.5	**0.7**
2012	Non-MO HealthNet	1.2	0.4	0.9	0.6	**0.9**
2013	Non-MO HealthNet	0.9	0.6	0.7	0.4	**0.7**
2014	Non-MO HealthNet	1.1	0.6	0.9	0.6	**0.9**
Change from 2000 to 2014		**-15.3%**	**-27.9%**	**-22.2%**	**-37.1%**	**-22.0%**
2000	MO HealthNet	7.6	3.4	4.5	2.6	**4.6**
2001	MO HealthNet	4.9	2.9	3.2	2.9	**3.6**
2002	MO HealthNet	5.3	3.2	3.6	3.0	**3.9**
2003	MO HealthNet	5.3	2.7	3.1	2.8	**3.7**
2004	MO HealthNet	5.0	2.3	2.5	2.7	**3.4**
2005	MO HealthNet	4.6	2.6	3.0	2.1	**3.2**
2006	MO HealthNet	5.0	3.1	3.0	2.3	**3.4**
2007	MO HealthNet	5.0	2.3	2.9	2.5	**3.4**
2008	MO HealthNet	5.6	2.0	2.7	1.9	**3.2**
2009	MO HealthNet	5.2	2.4	3.4	2.3	**3.5**
2010	MO HealthNet	4.8	2.0	2.6	2.0	**3.0**
2011	MO HealthNet	4.9	1.9	2.3	1.8	**2.9**
2012	MO HealthNet	4.4	1.9	2.6	1.8	**2.9**
2013	MO HealthNet	3.1	1.7	2.7	1.7	**2.4**
2014	MO HealthNet	3.9	2.1	3.3	2.0	**3.0**
Change from 2000 to 2014		**-48.8%**	**-39.4%**	**-25.8%**	**-22.6%**	**-36.5%**

Asthma ER Visits Age < 19

Benchmark = 10/1,000 pop.
Healthy People 2000

Rates per 1000 population

Cal. Year	Population	*Eastern*	*Central*	*Western*	*Other*	**State**
2000	CHIP	24.7	9.0	19.5	7.1	**13.3**
2001	CHIP	17.7	5.1	13.5	7.8	**11.4**
2002	CHIP	19.5	11.5	17.4	8.2	**13.3**
2003	CHIP	18.4	6.6	17.5	8.3	**12.3**
2004	CHIP	15.7	5.6	12.0	6.5	**10.1**
2005	CHIP	18.5	6.8	11.8	7.1	**11.3**
2006	CHIP	19.9	8.1	13.7	6.3	**11.9**
2007	CHIP	20.8	5.4	16.0	6.2	**12.4**
2008	CHIP	22.5	7.5	18.1	5.4	**13.3**
2009	CHIP	24.7	7.5	16.2	8.4	**14.8**
2010	CHIP	23.5	6.8	16.0	7.5	**14.1**
2011	CHIP	21.1	6.3	13.4	6.5	**12.4**
2012	CHIP	23.8	6.6	16.0	7.1	**13.9**
2013	CHIP	23.2	6.0	13.5	5.8	**12.7**
2014	CHIP	23.6	6.3	12.7	5.2	**12.6**
Change from 2000 to 2014		**-4.8%**	**-29.7%**	**-35.0%**	**-26.6%**	**-5.4%**
2000	Non-MO HealthNet	7.6	3.0	6.1	3.3	**5.5**
2001	Non-MO HealthNet	6.6	3.0	6.0	3.3	**5.2**
2002	Non-MO HealthNet	6.9	2.9	6.1	3.3	**5.4**
2003	Non-MO HealthNet	6.6	2.8	5.5	3.2	**5.1**
2004	Non-MO HealthNet	6.9	3.2	5.1	3.5	**5.3**
2005	Non-MO HealthNet	6.8	3.1	4.8	2.8	**5.0**
2006	Non-MO HealthNet	6.2	3.1	4.9	3.1	**4.8**
2007	Non-MO HealthNet	5.7	2.5	5.0	3.1	**4.5**
2008	Non-MO HealthNet	6.2	2.7	4.6	3.1	**4.7**
2009	Non-MO HealthNet	6.0	2.9	4.2	2.9	**4.5**
2010	Non-MO HealthNet	5.6	2.3	4.1	2.6	**4.1**
2011	Non-MO HealthNet	5.8	2.6	4.8	2.8	**4.4**
2012	Non-MO HealthNet	6.5	2.3	5.8	2.9	**4.9**
2013	Non-MO HealthNet	6.0	2.4	4.6	2.1	**4.3**
2014	Non-MO HealthNet	6.6	3.0	5.1	2.6	**4.8**
Change from 2000 to 2014		**-12.3%**	**0.4%**	**-16.0%**	**-21.7%**	**-12.6%**
2000	MO HealthNet	36.2	13.2	26.2	10.0	**21.7**
2001	MO HealthNet	28.1	10.7	22.8	9.7	**18.5**
2002	MO HealthNet	31.0	11.9	22.9	10.6	**19.9**
2003	MO HealthNet	28.0	11.6	20.2	13.4	**18.0**
2004	MO HealthNet	25.0	9.9	17.6	8.9	**16.0**
2005	MO HealthNet	26.5	11.1	17.8	8.8	**16.6**
2006	MO HealthNet	30.1	11.2	17.1	8.2	**17.3**
2007	MO HealthNet	28.1	11.2	18.7	8.6	**17.2**
2008	MO HealthNet	26.9	9.5	17.3	7.5	**16.3**
2009	MO HealthNet	28.8	11.1	18.5	8.1	**17.5**
2010	MO HealthNet	30.0	10.2	21.0	8.6	**18.5**
2011	MO HealthNet	29.0	9.4	19.0	8.9	**17.8**
2012	MO HealthNet	30.7	10.2	22.2	9.0	**19.3**
2013	MO HealthNet	28.9	9.2	19.4	7.3	**17.5**
2014	MO HealthNet	30.3	11.1	21.2	7.9	**18.7**
Change from 2000 to 2014		**-16.3%**	**-15.6%**	**-19.3%**	**-21.0%**	**-13.6%**

ER Visits Age < 19

Benchmark = 400/1,000 pop.

Health, United States, 2005, CDC

Rates per 1000 population

Cal. Year	Population	*Eastern*	*Central*	*Western*	*Other*	State
2000	CHIP	367.6	393.4	388.4	546.3	**463.4**
2001	CHIP	490.1	497.3	471.6	531.9	**506.1**
2002	CHIP	525.9	496.8	467.8	517.9	**508.1**
2003	CHIP	511.0	521.9	465.8	590.0	**508.7**
2004	CHIP	403.2	467.2	381.3	453.2	**426.2**
2005	CHIP	436.3	467.8	390.7	459.8	**439.8**
2006	CHIP	478.9	528.9	421.4	490.7	**477.1**
2007	CHIP	517.3	516.3	467.8	487.5	**495.2**
2008	CHIP	562.8	526.8	539.4	524.6	**539.1**
2009	CHIP	646.7	533.7	576.0	589.6	**595.3**
2010	CHIP	576.1	459.2	485.0	513.6	**518.4**
2011	CHIP	501.9	465.0	432.0	484.7	**475.6**
2012	CHIP	535.6	456.0	447.5	467.8	**481.6**
2013	CHIP	486.0	421.6	400.9	406.7	**431.4**
2014	CHIP	456.2	407.7	385.5	359.9	**402.0**
Change from 2000 to 2014		**24.1%**	**3.6%**	**-0.7%**	**-34.1%**	**-13.2%**
2000	Non-MO HealthNet	262.1	218.6	269.9	256.6	**257.9**
2001	Non-MO HealthNet	256.6	244.9	296.3	259.9	**265.0**
2002	Non-MO HealthNet	263.4	251.4	284.4	255.6	**264.7**
2003	Non-MO HealthNet	265.3	253.1	281.8	256.9	**265.5**
2004	Non-MO HealthNet	244.6	271.4	268.5	274.2	**260.4**
2005	Non-MO HealthNet	243.9	442.7	248.1	258.4	**251.0**
2006	Non-MO HealthNet	231.1	252.4	238.7	251.5	**240.3**
2007	Non-MO HealthNet	232.5	236.2	233.4	253.5	**238.9**
2008	Non-MO HealthNet	227.7	226.3	234.6	309.9	**247.1**
2009	Non-MO HealthNet	216.8	216.6	219.9	258.6	**227.0**
2010	Non-MO HealthNet	196.4	182.0	189.0	226.0	**199.7**
2011	Non-MO HealthNet	214.0	196.9	226.0	250.3	**223.1**
2012	Non-MO HealthNet	222.9	192.9	230.1	230.1	**222.3**
2013	Non-MO HealthNet	205.1	190.5	204.9	198.7	**201.6**
2014	Non-MO HealthNet	205.2	216.7	211.6	191.7	**204.9**
Change from 2000 to 2014		**-21.7%**	**-0.9%**	**-21.6%**	**-25.3%**	**-20.5%**
2000	MO HealthNet	713.6	681.7	637.0	656.8	**676.0**
2001	MO HealthNet	642.4	704.4	628.4	709.9	**671.0**
2002	MO HealthNet	674.9	710.0	581.7	708.6	**673.2**
2003	MO HealthNet	691.3	754.9	618.1	737.8	**700.7**
2004	MO HealthNet	596.3	700.9	557.1	654.1	**620.5**
2005	MO HealthNet	602.1	765.1	570.7	688.0	**662.5**
2006	MO HealthNet	696.9	547.5	575.4	697.4	**680.2**
2007	MO HealthNet	709.8	769.4	623.6	719.6	**702.0**
2008	MO HealthNet	717.6	727.6	711.6	703.8	**713.4**
2009	MO HealthNet	794.2	744.9	748.2	756.8	**765.6**
2010	MO HealthNet	740.8	654.7	666.6	684.8	**695.0**
2011	MO HealthNet	703.9	659.0	632.5	730.8	**690.5**
2012	MO HealthNet	747.8	658.6	659.2	670.1	**691.6**
2013	MO HealthNet	703.3	625.7	601.5	595.8	**636.9**
2014	MO HealthNet	697.1	649.3	603.5	566.4	**629.3**
Change from 2000 to 2014		**-2.3%**	**-4.8%**	**-5.3%**	**-13.8%**	**-6.9%**

Preventable Hospitalizations age < 19

Benchmark = 7.2/1,000 pop.

Kozak, Hall and Owings.

Rates per 1000 population

Cal. Year	Population	*Eastern*	*Central*	*Western*	*Other*	**State**
2000	CHIP	10.5	8.0	9.5	9.8	**9.7**
2001	CHIP	9.9	8.8	6.7	10.5	**9.4**
2002	CHIP	6.8	9.2	8.9	10.0	**8.9**
2003	CHIP	6.7	6.6	8.2	9.9	**8.0**
2004	CHIP	7.0	7.0	6.9	8.8	**7.7**
2005	CHIP	7.5	6.4	6.2	8.4	**7.5**
2006	CHIP	8.2	8.1	6.3	9.2	**8.2**
2007	CHIP	8.7	6.3	7.7	7.7	**7.8**
2008	CHIP	11.1	8.3	7.3	8.9	**9.1**
2009	CHIP	13.4	8.0	10.0	10.5	**10.9**
2010	CHIP	10.7	7.1	8.4	9.0	**9.1**
2011	CHIP	11.1	8.0	6.2	8.3	**8.7**
2012	CHIP	10.9	6.6	5.6	9.6	**8.7**
2013	CHIP	7.7	4.9	7.8	7.3	**7.2**
2014	CHIP	8.5	5.2	5.4	7.2	**6.9**
Change from 2000 to 2014		**-19.0%**	**-35.0%**	**-43.1%**	**-25.8%**	**-28.5%**
2000	Non-MO HealthNet	5.5	4.9	4.9	5.7	**5.4**
2001	Non-MO HealthNet	6.0	5.6	5.0	6.1	**5.8**
2002	Non-MO HealthNet	5.9	6.4	5.1	6.2	**5.9**
2003	Non-MO HealthNet	5.7	6.1	4.7	5.8	**5.5**
2004	Non-MO HealthNet	6.1	6.3	4.7	6.2	**5.8**
2005	Non-MO HealthNet	6.5	7.0	4.9	6.5	**6.2**
2006	Non-MO HealthNet	5.9	5.8	4.5	5.9	**5.5**
2007	Non-MO HealthNet	5.9	5.2	4.6	5.0	**5.6**
2008	Non-MO HealthNet	6.0	5.7	3.9	5.4	**5.3**
2009	Non-MO HealthNet	6.5	5.8	3.9	5.7	**5.6**
2010	Non-MO HealthNet	5.8	5.1	3.7	4.4	**4.9**
2011	Non-MO HealthNet	5.8	4.9	4.2	5.1	**5.1**
2012	Non-MO HealthNet	5.6	4.3	3.9	5.6	**5.1**
2013	Non-MO HealthNet	4.7	4.5	3.9	4.6	**4.5**
2014	Non-MO HealthNet	4.8	4.1	4.1	4.0	**4.3**
Change from 2000 to 2014		**-14.3%**	**-17.4%**	**-16.6%**	**-29.0%**	**-19.5%**
2000	MO HealthNet	17.8	15.0	13.5	16.6	**16.3**
2001	MO HealthNet	14.9	15.0	12.1	19.3	**16.1**
2002	MO HealthNet	13.7	14.8	12.0	18.2	**15.2**
2003	MO HealthNet	13.5	13.7	10.4	16.8	**14.2**
2004	MO HealthNet	12.8	12.5	10.6	16.1	**14.0**
2005	MO HealthNet	13.3	14.5	11.3	17.0	**14.5**
2006	MO HealthNet	14.3	14.7	11.3	17.7	**15.0**
2007	MO HealthNet	14.3	13.6	11.1	17.1	**14.7**
2008	MO HealthNet	16.5	13.5	10.6	17.1	**15.0**
2009	MO HealthNet	17.5	15.8	12.6	19.0	**16.7**
2010	MO HealthNet	15.2	12.4	11.0	15.7	**14.1**
2011	MO HealthNet	14.6	11.6	9.3	13.4	**12.6**
2012	MO HealthNet	13.3	11.7	9.0	14.7	**12.6**
2013	MO HealthNet	11.1	10.8	9.8	14.0	**11.7**
2014	MO HealthNet	11.8	10.1	10.1	12.6	**11.4**
Change from 2000 to 2014		**-33.5%**	**-32.7%**	**-25.5%**	**-23.7%**	**-29.6%**

APPENDIX II:

DMJ-DSS Wrap-Around Service Codes and Titles

Review period: July 1, 2015 - June 30, 2016

Wrap-Around Services (for children with SED and those affected by Substance Abuse)	
Procedure Code	**Description**
02500H	FAMILY SUPPORT
20000H	CASE MNGMT-BACHELOR IND
20001H	CASE MNGMT-PARAPROFESS IND
20003H	CASE MNGMT-PHYSICIAN IND
20004H	CASE MNGMT-LIC QMHP IND
20005H	CASE MNGMT-LIC PSYCH IND
39601W	WRAP-AROUND SRVCS-YOUTH IND
39603W	WRAP-AROUND SRVCS ADULT AS
440001	RESPITE CARE - IND
Y3127K	TARGET CASE MGMT (TCM) YTH
Y3128K	TARGET CASE MGMT (TCM) YTH
H0036K	COMMUNITY SUPPORT SERVICES
T1016A	CASE MANAGEMENT EACH 15 MINS
H0045H	RESPITE NOT-IN-HOME PER DIEM

APPENDIX III

Premium Chart, July, 2015

MO HealthNet for Kids - CHIP Premium Chart Effective July 1, 2015			
Family Size	**Percent of FPL**	**Monthly Income**	**Premium Amount**
1	>150	$1472.01 to $1815.00	$14
1	>185	$1815.01 to $2207.00	$45
1	>225	$2207.01 to $2943.00	$110
2	>150	$1992.01 to $2456.00	$19
2	>185	$2456.01 to $2987.00	$61
2	>225	$2987.01 to$ 3983.00	$149
3	>150	$2512.01 to $3098.00	$23
3	>185	$3098.01 to $3767.00	$77
3	>225	$3767.01 to $5023.00	$188
4	>150	$3032.01 to $3739.00	$28
4	>185	$3739.01 to $4547.00	$93
4	>225	$4547.01 to $6063.00	$227
5	>150	$3552.01 to $4380.00	$33
5	>185	$4380.01 to $5327.00	$109
5	>225	$5327.01 to $7103.00	$266
6	>150	$4072.01 to $5022.00	$38
6	>185	$5022.01 to $6107.00	$125
6	>225	$6107.01 to $8143.00	$305
7	>150	$4592.01 to $5663.00	$43
7	>185	$5663.01 to $6887.00	$141
7	>225	$6887.01 to $9183.00	$344
8	>150	$5112.01 to $6304.00	$48
8	>185	$6304.01 to $7667.00	$157
8	>225	$7667.01 to $10223.00	$383
9	>150	$5632.01 to $6946.00	$53
9	>185	$6946.01 to $8447.00	$173
9	>225	$8447.01 to $11263.00	$422
10	>150	$6152.01 to $7587.00	$57
10	>185	$7587.01 to $9227.00	$188
10	>225	$9227.01 to $12303.00	$461
11	>150	$6672.01 to $8228.00	$62
11	>185	$8228.01 to $10007.00	$204
11	>225	$10007.01 to $13343.00	$500
12	>150	$7192.01 to $8870.00	$67
12	>185	$8870.01 to $10787.00	$220
12	>225	$10787.01 to $14383.00	$539
Premium information for family sizes of 13+ is available upon request.			