MoHealthNet

STATE OF MISSOURI

CHILDREN'S HEALTH INSURANCE PROGRAM AND SHOW ME HEALTHY BABIES

ANNUAL REPORT

DEPARTMENT OF SOCIAL SERVICES

DECEMBER 2020

EXECUTIVE SUMMARY

Established in 1998, the Missouri Children's Health Insurance Program (CHIP) provides essential health services to children in low-income families. As of December 2019, more than 96,000 children who would otherwise not have access to health coverage were enrolled in the program. Research has shown that access to healthcare helps improve both short-term and long-term outcomes for children. The investment in coverage for unborn children through the State of Missouri's (State's) Show Me Healthy Babies (SMHB) program helps improve birth outcomes for babies through the provision of prenatal care for pregnant mothers. For the State, it has been a winning investment. It has helped keep Missouri's children healthy at minimal costs to taxpayers.

This CHIP and SMHB annual report describe in further detail the history and current operations of the Missouri CHIP program, which includes the SMHB program, as well as an evaluation of the program's goals. These quality goals, presented below, align with the State's overall quality strategy for MO HealthNet.

GOAL 1	GOAL 2	GOAL 3	GOAL 4	GOAL 5
				
Reduce the number of children and unborn children in Missouri without health insurance coverage.	Ensure appropriate access to care.	Promote wellness and prevention.	Ensure cost-effective utilization of services.	Promote member satisfaction with experience of care.

While there is positive information to report on each of these goals, Goal 4 in particular shows that CHIP has helped steer children to preventive care and better access to care in the community. This results in fewer emergency room visits and hospital stays when this level of service was unnecessary. Missouri's children are healthier as a result, and limited State resources are more effectively spent on less costly care.

The rate of asthma-related hospital admissions and preventable emergency department visits among children enrolled in CHIP declined steadily in recent years compared to populations not enrolled in CHIP. Pediatric asthma is a chronic, but treatable, condition and regular access to preventive care provided through CHIP has meant that families are able to better manage the condition and avoid traumatic and costly emergency visits. The rate of asthma-related emergency department visits among children enrolled in CHIP continue to be below the national benchmark and continue to be below the national average. Additionally, overall trends in preventable emergency department visits in the State are declining. Between 2001 and 2018, the rate of

preventable hospitalizations decreased by 43% for those enrolled in CHIP and by 50% for those enrolled in Missouri's non-CHIP Medicaid program. This is compared to a decline of only 23% for those not on Medicaid or CHIP.

MO HealthNet for Kids – Medicaid/CHIP Program	
…helps improve outcomes for Missouri's children	…is helping to keep children healthier now and in the long term.
…makes good economic sense for Missouri	…means relative minimal costs to the State

CHIP is financed jointly by the state and federal government.

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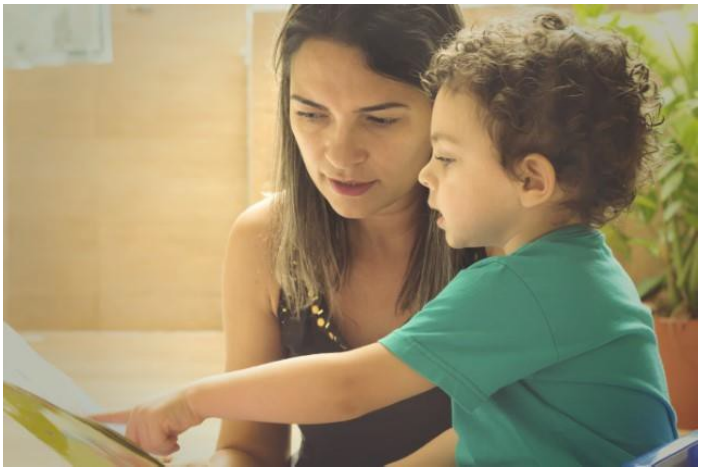
INTRODUCTION

The scope of this report is to address the statutory requirement to report on Missouri's Children's Health Insurance Program (CHIP) and Show Me Healthy Babies (SMHB) as required by State law (Sections 208.650 and 208.662.1 of the Revised Statutes of Missouri). Broadly, the report includes an evaluation of CHIP goal performance, including those outlined for the SMHB program.

THE HISTORY OF CHIP

When Congress enacted CHIP in 1997, there was growing concern about the rising uninsured rate among children in families with annual income just above the Medicaid income thresholds. Since its passage, the national rate of uninsured children has steadily declined, however, in 2018 this rate increased by 0.6% nationally.[1]



CHIP health care coverage reached over 9.6 million children in Fiscal Year (FY) 2018.[2]

While improved access to health care coverage is the overarching goal, there are several additional benefits tied to expanded access to health care coverage. Notably, CHIP has reduced unmet health care needs and provided greater financial protection for families in meeting those health care needs compared to children who were uninsured.[3]

Research has shown access to Medicaid and CHIP have significant benefits to children and their families. With access to Medicaid, children in low-income families receive essential healthcare services and experience long-term benefits, including better health status, greater academic achievement, and increased future earnings. In addition, families with access to Medicaid and CHIP are less likely to experience financial insecurity and have medical debt.[4]

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[1] https://www.census.gov/library/stories/2019/09/uninsured-rate-for-children-in-2018.html

[2] https://www.kff.org/other/state-indicator/annual-chip-enrollment/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] https://www.urban.org/sites/default/files/publication/33706/413276-CHIPRA-Mandated-Evaluation-of-the-Children-s-Health-Insurance-Program-Final-Findings.PDF

[4] https://www.americanprogress.org/issues/healthcare/reports/2019/06/12/470996/childrens-health-care-access-improve-universal-coverage-plans/

STATES AND THE CHIP PROGRAM

While CHIP has been successful in reducing the rate of uninsured children, it has also empowered states to design systems of coverage that meet state-specific needs. States can operate CHIP programs as a CHIP Medicaid expansion, a separate CHIP program or a combination of these two approaches. As of September 2007, the Missouri CHIP program has operated through a combination approach. Missouri receives a federal CHIP allotment based on its recent CHIP spending plus a growth factor.

Missouri has 2 years to spend each allotment and the federal government can redistribute any unspent funds to other states.[7]

Enhanced Federal Medical Assistance Percentage (E-FMAP)

86.96%	75.47%
FY 2020 E-FMAP	FY 2021 E-FMAP

The CHIP FMAP rate for Missouri is significantly higher than the FMAP rate, which is 65.65%. In State Fiscal Year (SFY) 2020, approximately $153 million was spent on services for CHIP populations, with $124 million financed by the federal government.

With such a large percentage of CHIP funding being financed by the federal government and dependent on both authorization and appropriations enacted by Congress, uncertainty about CHIP reauthorization and appropriations in recent years has created concerns among states about potential interruptions in CHIP services. However, in 2018, Congress passed legislation to provide CHIP funding through FY 2027, which has provided longer-term clarity for CHIP operations at the state level.[8] The E-FMAP rate, which adds 23% to the regular CHIP FMAP rate, was reduced in FY 2019. The continuing resolution provides for an additional E-FMAP rate of 11%, rather than the previous 23%, through FY 2020.

While this will result in a higher State share for CHIP,
the E-FMAP rate will still be higher than the Medicaid FMAP.

State administrative law (13 CSR 70-4.080) establishes the methodology used to determine CHIP enrollment eligibility.[9] Generally, in order for a child to be eligible for CHIP, a family must have an

[7] https://www.macpac.gov/subtopic/financing/

[8] A continuing resolution signed into law on January 22, 2018 (P.L. 115-120) and the Bipartisan Budget Act of 2018 signed into law on February 9, 2018 (P.L. 115-123) provided CHIP funding through FY 2027.

[9] https://s1.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c70-4.pdf

annual modified adjusted gross income (MAGI) of less than 300% of the federal poverty level (FPL). For children in families with MAGI between 150% and 300% of the FPL, there is an additional eligibility test of access to affordable coverage (affordability is defined on a scale from $77 to $192 per month based on family size and income).

Comprehensive Eligibility Requirements for Families with Gross Income of More Than 150% of the FPL

Parents/guardians of uninsured children must certify the child does not have access to affordable employer-sponsored insurance (ESI) or other affordable, available health insurance coverage.

Infants under one-year-old in families with gross incomes of less than 196% of the FPL are exempt from premiums.

Children in families with gross incomes of more than 150% and up to 225% of the 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% and up to 300% of the FPL are eligible for coverage 30 calendar days after 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% of the FPL are eligible for coverage under the SMHB program. SMHB participants can be determined presumptively eligible and have no cost-sharing requirements.

Premiums:

- Total aggregate premiums cannot exceed 5% 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. A chart describing premiums effective July 1, 2019 is included as Appendix 1.

SMHB PROGRAM DETAILS

Missouri operates the SMHB program as a separate CHIP coverage option, which was created by State legislation enacted in 2014. SMHB was established to provide health coverage to unborn children by expanding coverage to mothers. The SMHB program enrollment began in 2016. The program was born from the recognition that children of women who have access to Medicaid during their pregnancy have better health outcomes that reach into adulthood, including reduced rates of obesity and hospitalizations, and improvements in oral health.[10] Without the SMHB program, the newborn would still be covered under Medicaid or CHIP, but associated healthcare costs would be greater due to the lack of prenatal care. With health coverage through SMHB, there is purposeful benefit of improving the health of the expectant mother, and in turn, the health of the child at birth.

SMHB

- Provides health coverage to unborn children by expanding coverage to mothers.
- Enrollment began in 2016.
- Covers pregnant women between 201% and 300% of FPL.
- Covers all prenatal care and pregnancy related services.

The SMHB program is separate from CHIP in that it covers pregnant women between 201% and 300% of the FPL. Covered services for an unborn child enrolled in the SMHB program include all prenatal care and pregnancy-related services for the mother which benefit the health of the unborn child, and promote healthy labor, delivery and birth. This also includes services such as case management, prenatal and postpartum home visits, breastfeeding education and electric breast pumps.

SMHB Eligibility Requirements

Pregnant

Household income up to 300% of the FPL

Uninsured

No access to ESI or affordable private insurance which includes maternity benefits (prenatal, labor and delivery, and post-partum coverage).

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.

SMHB has no waiting periods, which guarantees presumptive eligibility for the unborn child. The child will be covered from enrollment up to one year after birth (at that time the child may be eligible

[10] https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf

for Medicaid or CHIP). To help foster a child's healthy upbringing, certain eligible mothers may continue to receive pregnancy-related and postpartum care for up to 60 days after birth.

Table 1 illustrates income levels for Medicaid, CHIP and SMHB for children and pregnant women.

TABLE 1 CHIP AND SMHB 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)	SMHB (Non-Premium)	SMHB (Non-Premium)	SMHB (Non-Premium)

According to a study published in the American Journal of Obstetrics and Gynecology, prenatal care is associated with fewer preterm births[11], with far-reaching impacts on the overall health of the infant:

Medical Issues

Babies who are born prematurely suffer from a host of medical problems and are at considerable risk for long term impairment, including physical disability, cerebral palsy, mental retardation, and attention-deficit and hyperactivity disorder (ADHD).

NICU Infants

Medical experts estimate that a quarter of infants leaving neonatal intensive care units (NICUs) have chronic health problems. These chronic problems, including developmental delays and disabilities, put premature babies at risk for a variety of poor social outcomes as they age including the inability to hold employment, extended residence in a parent's household, lowered socio-economic status, lower cognitive test scores, and behavioral challenges.

Infant Death Risk

In the presence of pregnancy complications, the lack of prenatal care was associated with increased preterm birth rates ranging from 1.6-fold to 5.5-fold for various antenatal high-risk conditions.[12]

11 https://www.researchgate.net/publication/11355248_The_impact_of_prenatal_care_on_neonatal_deaths_in_the_presence_and_absence_of_antenatal_high-risk_conditions

12 https://www.ajog.org/article/S0002-9378(02)00404-0/fulltext

Benefits of SMHB

The State's investment in prenatal care for low income women through its SMHB program not only has the potential to improve health outcomes for newborns but can also help save precious State resources.

Prenatal Care Generates Cost Savings (Particularly for Women with High-Risk Pregnancies)

Intensive prenatal care reduced hospital and NICU admissions		Cost Savings between $1,768 to $5,560 per birth, according to March of Dimes[13]
Average hospital charge for an infant of normal weight – $3,200		Average hospital charge for low birthweight babies[14] – $27,200

As discussed, there is growing evidence that connects the benefits of access to health coverage to better health outcomes and other social and economic benefits, which would be lost without CHIP and the SMHB program. Health care costs for families with low incomes would increase due to higher out-of-pocket expenses like deductibles. The burden would be particularly significant for children with special health care needs due the high cost of marketplace plans for that population. Some families might not be able to afford the increased costs, resulting in an increase in the number of uninsured children.[15] Without the SMHB program, healthier births would decline, but Missouri would still remain obligated to cover these children after birth, likely at a greater cost due to increased health needs.

[13] https://www.healthaffairs.org/do/10.1377/hblog20160219.053241/full/
[14] https://www.americashealthrankings.org/explore/annual/measure/birthweight/state/ALL
[15] https://familiesusa.org/resources/the-childrens-health-insurance-program-chip/

EVALUATION OF CHIP GOALS

INTRODUCTION TO ANALYSIS

As previously noted, the Department of Social Services ("DSS" or the "Department") is required to submit an annual report on CHIP and SMHB that provides analysis on specific objectives/items identified by the Legislature. DSS is also required, by the Centers for Medicare & Medicaid Services (CMS), to develop a Quality Improvement Strategy (QIS). Missouri's QIS, which was updated in 2018, provides the framework to communicate the State's vision, goals, objectives and measures that address access to care, wellness and prevention, chronic disease care, cost-effective utilization of services and customer satisfaction. The QIS includes specific metrics that will be used to measure progress on a yearly and longer-term basis for each goal. While the QIS does not require measures to be broken out by CHIP or SMHB, it does include metrics that are specific to children as well as to pre- and post-natal care.[16] DSS is presenting its required analysis of the CHIP and SMHB programs in alignment with the framework outlined in the QIS quality goals. Specifically, this report is presented according to the four goals in the QIS, as well as one additional goal specifically related to reducing the number of children and unborn children in Missouri without health insurance. The report is structured according to the following goals, along with the relevant data and accompanying analysis that is required by statute:

GOAL 1	GOAL 2	GOAL 3	GOAL 4	GOAL 5
				
Reduce the number of children and unborn children in Missouri without health insurance coverage.	Ensure appropriate access to care.	Promote wellness and prevention.	Ensure cost-effective utilization of services.	Promote member satisfaction with experience of care.

[16] See Quality Improvement Strategy: 2018 Goals, Objectives and Measures; available at https://dss.mo.gov/mhd/mc/pdf/2018-quality-strategy.pdf

Prior to 2018, the CHIP and SMHB report was focused around study questions rather than quality goals. DSS believes focusing the report on quality goals is helpful in providing consistent analysis and support for its mission.

EXPLANATION OF DATA SOURCES

This 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), Section for Epidemiology for Public Health Practice, CY 2018
- U.S. Census Data, 2000–2019
- Claims data from CY 2019
- Eligibility data from CY 2019
- Monthly Management Report
- Health Effectiveness Data and Information Set (HEDIS) data from 2014–2019
- Consumer Assessments of Healthcare Providers and Systems (CAHPS) data from CY 2019
- 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 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 and are continued to be reported on a calendar year basis.

CHIP/SMHB GOAL 1

GOAL 1

Reduce the number of children and unborn children in Missouri without health insurance coverage.

The mission of DSS is "to lead the nation in building the capacity of individuals, families, and communities to secure and sustain healthy, safe, and productive lives."[17]

Furthermore, the vision of the MO HealthNet Division is to build a best in class Medicaid program that addresses the needs of Missouri's most vulnerable in a way that is financially sustainable. Reducing the number of uninsured children and unborn children is fundamental to these goals and would not be possible without the CHIP and SMHB programs.

Below are details of enrollment information with separate discussions for the CHIP and SMHB programs. While enrollment has been relatively stable over time, each participant had access to medically necessary services. As described above, the benefits of access to health coverage directly links to better health outcomes and other social and economic benefits, but those benefits can be difficult to measure.

CHIP Enrollment

The information provided on the following page illustrates the number of CHIP participants by month, county, age, race and gender. Over the course of CY 2019, monthly CHIP enrollment ranged from 95,521 to 102,127 participants. Note these numbers do not include SMHB.

[17] See Quality Strategy: Mission Statement (at pg. 6); available at https://dss.mo.gov/mhd/mc/pdf/2018-quality-strategy.pdf

TABLE 2 CY 2019 CHIP PARTICIPANTS BY ELIGIBILITY CATEGORY (EXCLUDING SMHB)

MONTH	MEDICAID/CHIP (NON-PREMIUM)[18]	CHIP (NON-PREMIUM)	CHIP (PREMIUM)	TOTAL
January	59,536	1,796	40,795	102,127
February	58,770	1,803	40,465	101,038
March	57,731	1,891	40,254	99,876
April	58,554	1,775	38,082	98,411
May	56,698	1,832	38,365	96,895
June	56,714	1,928	39,388	98,030
July	56,018	1,906	38,999	96,923
August	55,077	1,967	39,715	96,759
September	53,195	1,979	40,347	95,521
October	53,069	2,025	41,097	96,191
November	52,241	2,060	41,509	95,810
December	51,593	2,081	42,669	96,342

Data Source: CY 2019 eligibility data and Monthly Management Reports

[18] As a result of provisions contained in the Affordable Care Act children ages 6–18 in families with incomes between 100% of the FPL and the MAGI equivalent of 133% of the FPL are now a mandatory group under the Medicaid program. Before that requirement, Missouri covered these kids under CHIP. The Center for Medicare and Medicaid Services (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”.

TABLE 3 DECEMBER 2019

GENDER	AGE	MEDICAID/CHIP (NON-PREMIUM)
	5 to 9	8,692
	10 to 14	10,025
	15 to 19	7,739
Male	**Total**	**26,456**
	5 to 9	8,219
	10 to 14	9,436
	15 to 19	7,482
Female	**Total**	**25,137**
Total		**51,593**

TABLE 4 DECEMBER 2019 MEDICAID/CHIP (NON PREMIUM)

RACE ETHNICITY	MEDICAID/CHIP (NON-PREMIUM)
White / Other	36,988
Asian	1,014
Black/African American	9,386
American Indian/Alaskan Native	138
Native Hawaiian/Pacific Islander	167
Multi-Racial	1,069
Unknown	2,831
Total	**51,593**

Medicaid and CHIP (excluding SMHB) Enrollment by county for December 2019 is provided in Appendix 2.

SMHB Enrollment

The information provided below illustrates the number of SMHB participants by month, county, age, race and gender. This information was summarized based on eligibility data provided by DSS. Due to the nature of the program, enrollment in any given month may decrease as women will no longer be in the program when their eligibility ends.

TABLE 5 CY 2018 SMHB PARTICIPANTS

Month	SMHB	Month	SMHB
January	4,158	July	4,418
February	4,196	August	4,420
March	4,322	September	4,481
April	4,342	October	4,507
May	4,299	November	4,503
June	4,353	December	4,542

Data Source: CY 2019 eligibility data

SMHB enrollment by county for December 2019 is provided in Appendix 3.

SMHB is instrumental in improving birth outcomes and providing coverage to unborn children who would otherwise not have access to health insurance. In the first year of SMHB (CY 2016), 1,069 babies were enrolled in SMHB. In CY 2019, 2,758 babies were enrolled. All of these children became eligible for regular CHIP/Medicaid upon birth.

TABLE 7 CHILDREN BORN TO SMHB WOMEN BY MONTH

MONTH	YEAR	SMHB INFANTS
January	2019	179
February	2019	165
March	2019	199
April	2019	206
May	2019	207
June	2019	273
July	2019	214
August	2019	225
September	2019	180
October	2019	211
November	2019	170
December	2019	185
Total Current Enrollment Ending Dec 31, 2019		**2,758**

Data Source: CY 2019 eligibility data

Table 7 shows the number of children born to SMHB women in 2019. Table 8 compares newly enrolled pregnant women by month in the SMHB program and traditional Medicaid (MPW stands for MO HealthNet pregnant women). The MPW new enrollees were limited to the Pregnant Women Medicaid Eligibility (ME) codes (18, 45 and 61). Over the course of the year there were 2,826 unique pregnant women covered by the program. Due to the nature of the program, the enrollment in any given month may decrease as women will no longer be in the program when their eligibility ends. On December 31, 2019, there were 833 pregnant women enrolled in the SMHB program and 1,993 MPW.

TABLE 8 NEWLY ENROLLED PREGNANT WOMEN BY MONTH			
Month	**Year**	**SMHB Women**	**MPW**
January	2019	84	130
February	2019	61	135
March	2019	84	156
April	2019	89	165
May	2019	82	159
June	2019	62	152
July	2019	73	168
August	2019	74	178
September	2019	74	170
October	2019	64	176
November	2019	62	208
December	2019	24	196

Data Source: CY 2019 eligibility data

SMHB Deliveries Compared to Other Programs

Tables 9 and 10 illustrate enrollment and deliveries across the SMHB, CHIP and non-CHIP (Medicaid) programs in Missouri. In comparing 2018 to 2019, the number of CHIP deliveries increased by approximately 20%, non-CHIP (Medicaid) deliveries increased by approximately 1%, and SMHB deliveries increased by approximately 7%. There was an increase in CHIP enrollment, and SMHB continues to see an increase in the number of enrollments and deliveries due to increased awareness of the program.

TABLE 9 TOTAL DELIVERIES IN 2019			
	SMHB	**CHIP**	**NON-CHIP (MEDICAID)**
Managed Care	1,887	5	26,069
Fee-for-Service (FFS)	217	0	2,706
Total	**2,104**	**5**	**28,775**

TABLE 10 CHIP AND SMHB ENROLLMENT AND DELIVERY CHANGES CY 2018 AND CY 2019

	DEC 2018 ENROLLMENT	DEC 2019 ENROLLMENT	CHANGE	2018 DELIVERIES	2019 DELIVERIES	CHANGE
CHIP	87,693	194,274	54.9%	4	5	20.0%
SMHB	3,478	4,542	23.4%	1,967	2,104	6.5%

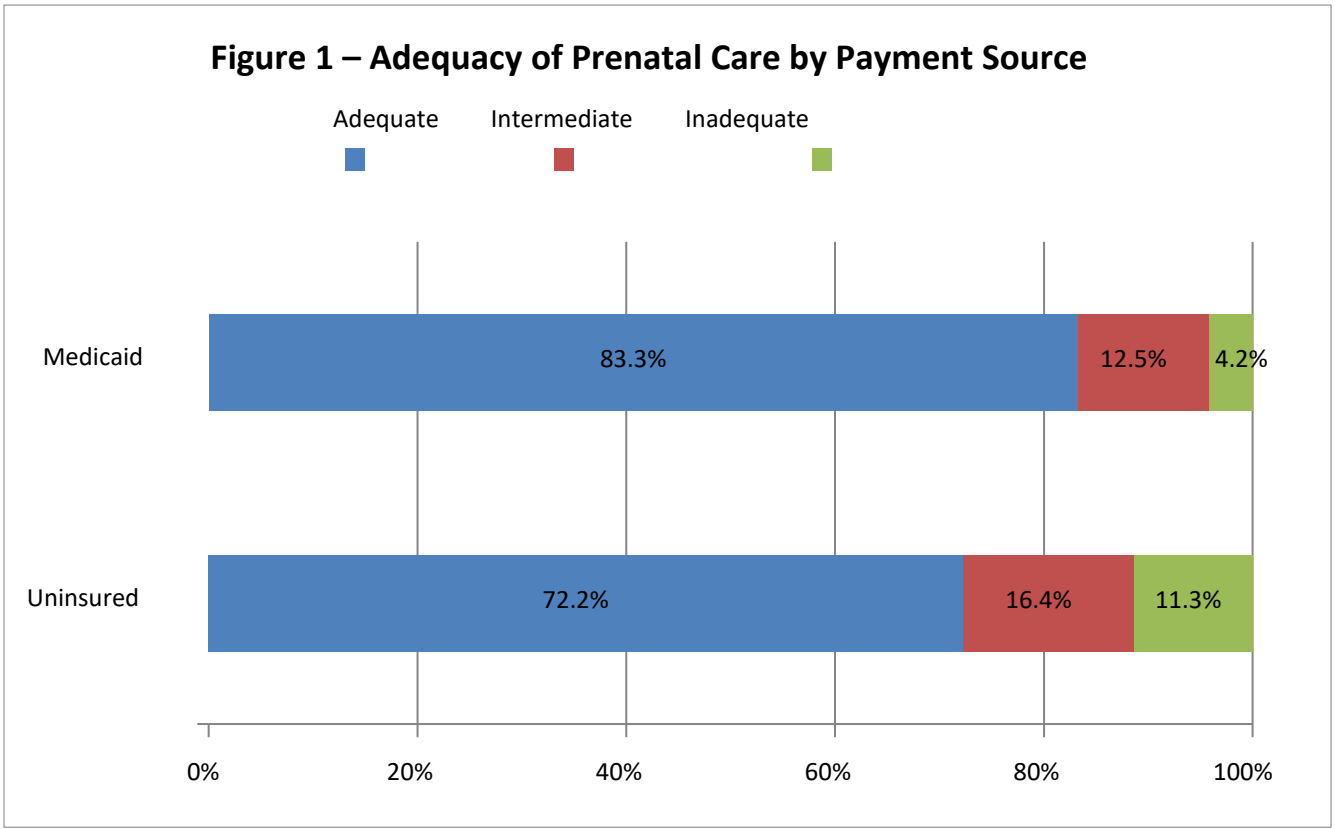
Based on the eligibility criteria for the SMHB program, enrollees in general were previously uninsured. Comparison points to the SMHB program would be most relevant to pregnant women in the uninsured population; however, since the comparison population is uninsured, information is unavailable regarding their utilization of health care services. Therefore, this report focuses on different proxies or indicators that are likely related to the receipt of proper prenatal care.

Table 11 shows the number of births identified with very low birth weight (VLBW), which is defined by a birth weight under 1500 grams. Similar to the delivery counts shown in Table 10, these counts were determined by analyzing 2019 claims data. These metrics can serve as an indication of the prenatal services being received by pregnant mothers in each of the eligibility groups. It is expected that without adequate prenatal care the prevalence of VLBW deliveries increase.

TABLE 11 VLBW COUNT

	SMHB	CHIP	NON-CHIP
Managed Care	16	0	461
FFS	3	1	205
Total	19	1	666

As discussed above, studies have shown that the earlier a pregnant woman is enrolled or has access to health coverage, the more likely she is to receive prenatal services. Figure 1 below contains results from a study by the Health Resources & Services Administration (HRSA), indicating that only 72% of uninsured women receive adequate prenatal care while 11% receive inadequate prenatal care, compared to 83% and 4%, respectively, for Medicaid.[19]



Data Source: HRSA study on prenatal care

[19] https://mchb.hrsa.gov/sites/default/files/mchb/Data/Chartbooks/child-health-2014.pdf

Overall Impact of CHIP and SMHB on Health Care of Missouri Residents

The introduction to this report provides details on studies that have analyzed the impact of health insurance coverage on children's health. Studies clearly show that children with insurance have better health outcomes and higher academic success rates than uninsured children. Notably:

- Studies suggest there is a positive correlation between access to health insurance coverage and academic achievement.[20] Indeed, 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.[21]

- Emerging evidence suggests that the health benefits continue through adulthood.[22]

- A 2016 report of compiled research published by the Kaiser Family Foundation found both Medicaid and CHIP provide broad benefits and cost-sharing protections for low-income children. Children enrolled in Medicaid received a comprehensive benefit package that includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, long-term care, many rehabilitative services, and service provided at Federally Qualified Health Centers (FQHCs). Under EPSDT, children are guaranteed comprehensive coverage including access to physical and mental health therapies, dental and vision care, personal care services and durable medical equipment.[23]

- 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 pre-CHIP rates. Evidence further indicates that increased access is accompanied by reduced emergency department use.[24]

[20] http://jhr.uwpress.org/content/51/3/727.short

[21] Children's Health Coverage: The Role of Medicaid and CHIP and Issues for the Future. The Kaiser Family Foundation, March 2016.

[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4785872/#R49

[23] https://www.kff.org/report-section/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future-issue-brief/

[24] https://www.kff.org/report-section/the-impact-of-the-childrens-health-insurance-program-chip-issue-brief/

CHIP/SMHB GOAL 2

GOAL 2

Ensure appropriate access to care

After a child is enrolled in CHIP, it is imperative to ensure the child has access to care to take full advantage of the program. Access can be defined by, among other things, availability of providers accepting CHIP/SMHB participants who are located a reasonable distance from the participant's home. DSS measures access in managed care by reviewing provider directories and panels, maintaining appointment time and distance standards, and monitoring complaints.

The appointment time and distance standards are addressed in the QIS. In addition, DSS reviews CAHPS results to monitor participants' experiences with the Medicaid and CHIP programs. The CAHPS data is useful when considering whether members are receiving appropriate access to care.

In addition, the statute requires the Department to consider the effect of the CHIP program on the number of children covered by private insurance. Appropriate access to care also means ensuring that individuals who have access to private health insurance are utilizing that coverage.

Relevant CAHPS Information

CAHPS results for three important indicators related to children's access to both routine and specialty care are included in Table 13. Results for Missouri's CHIP program show that Missouri is above the national average in urgent and specialty care access measures, and is within four percent of the national average for the preventive care access measure.

TABLE 13 CAHPS INFORMATION ON ACCESS TO CARE FOR CHILDREN ENROLLED IN CHIP

CAHPS MEASURE	MISSOURI	NATIONAL HMO AVERAGE
In the last six months, when your child needed care right away, how often did your child get care as soon as he or she needed?	94.3%	94.16%
In the last six months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as he or she needed?	86.67 %%	90.45 %%
In the last six months, how often did you get an appointment for your child to see a specialist as soon as he or she needed?	87.93 %	83.18 %

Effect of CHIP on Number of Children Covered by Private Insurers

It is important to consider the effect of CHIP on the number of children covered by private insurance, and whether the expansion of health care coverage to children whose gross family income is above 185% FPL has any negative effect on these numbers.

"Crowd out" in the context of health insurance occurs when public coverage serves as a substitute for private insurance coverage. In such circumstances, individuals may choose to forgo coverage available from their employer or in the individual health insurance 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.

When CHIP reauthorization legislation passed into law in 2008, Congress required states to develop procedures to prevent crowd out. Specifically, the law required states to adopt efforts to ensure that "the insurance provided under the State child health plan does not substitute for coverage under group health plans."[25] In Missouri's CHIP program, the State requires a six month look-back period for health insurance when determining eligibility to children in families with income above 150% of FPL.[26] Additionally, the State employs other eligibility processes to prevent crowd out, including requiring quotes from private insurers as proof that affordable insurance alternatives do not exist, and a waiting period for those who drop private coverage without good cause.

The largest source of coverage for children continues to be employer-sponsored insurance (ESI). The share of children enrolled in Medicaid/CHIP and direct purchase coverage (which includes federal and state marketplaces) declined. Even an increase in ESI coverage for children was not able to compensate for the decline in publicly-funded coverage, leading to an increase in uninsured children overall.[27]

In Missouri specifically, the State CHIP program has requirements to prevent crowd out, and evidence from 2012 to 2019 shows that the rate of ESI rate has increased slightly and the rate of "direct purchase" insurance has decreased. Both are indicators that CHIP has not been substituted for private insurance coverage. Missouri's rate of ESI and "direct purchase" insurance also stands above national trends (51.2% ESI nationally versus 55.00% in Missouri in 2019; 6.7% "direct purchase" insurance nationally versus 7.1% in Missouri in 2019). Over this same period, the rate of uninsured children in Missouri also increased.

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

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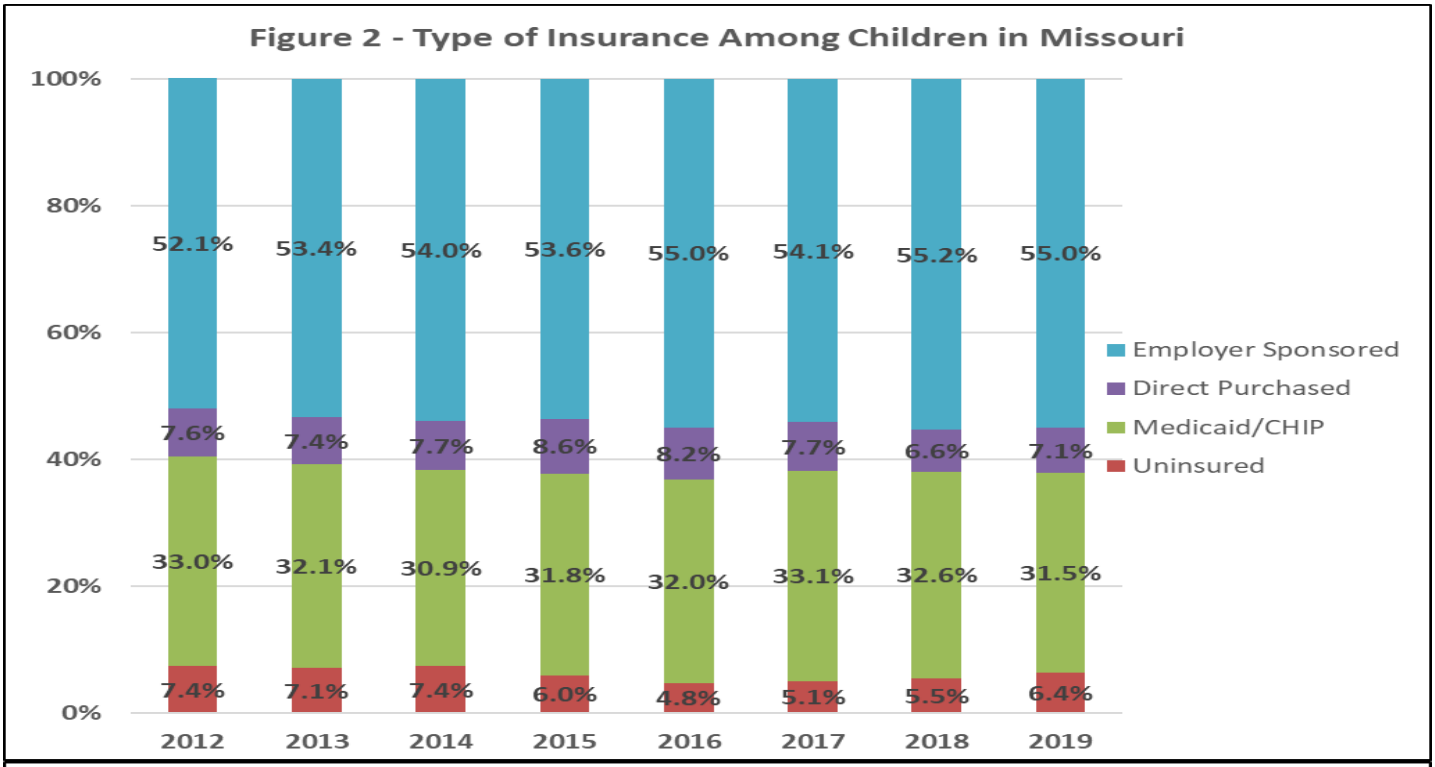
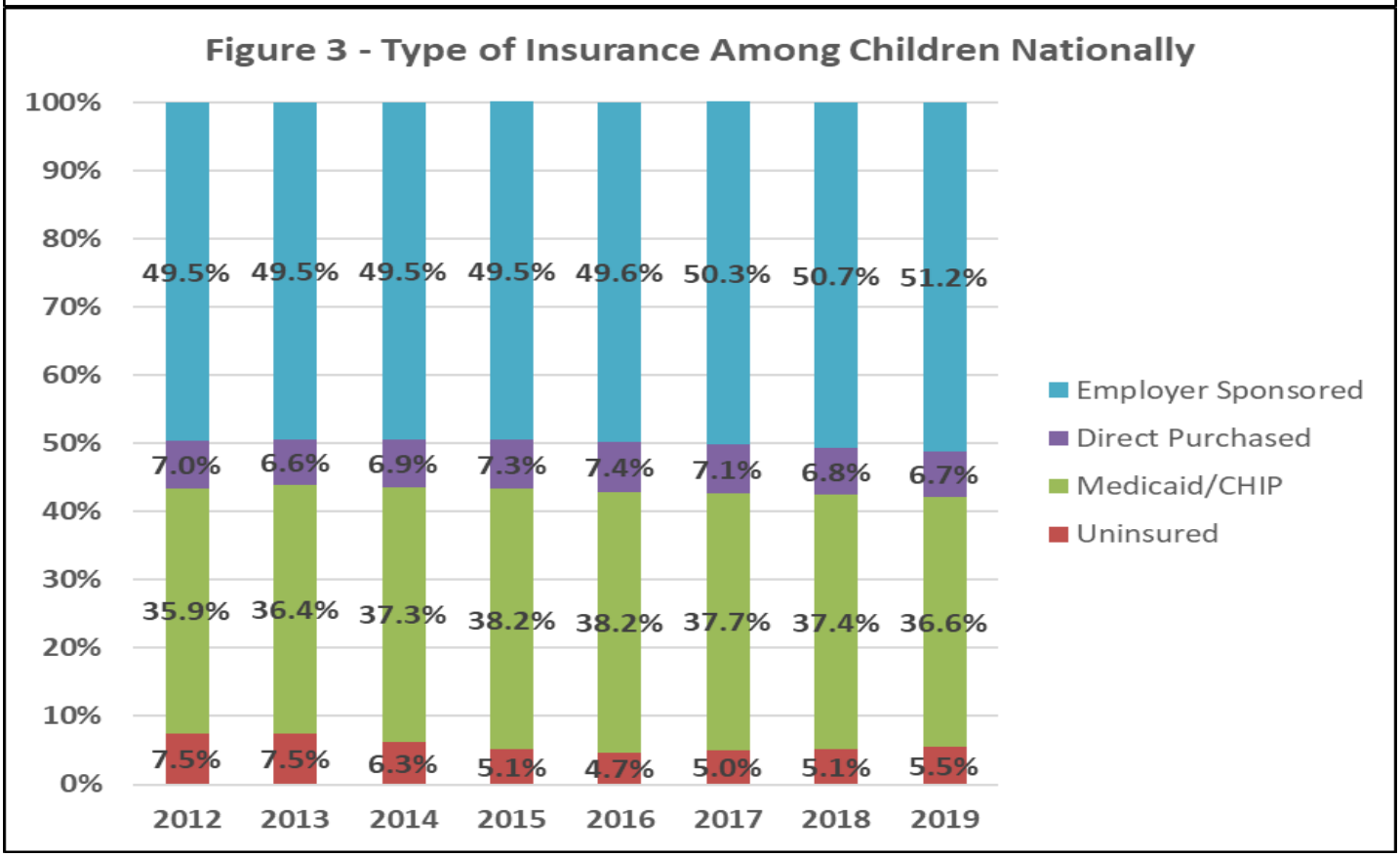
[25] 42 USC 1397bb(b)(3)(C)

[26] https://www.medicaid.gov/CHIP/Downloads/MO/MO-17-0002.pdf

[27] https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018_Final_asof1128743pm.pdf

nation in maintaining private health insurance rates, both in overall percentage and over the last eight years. Figures 2-3 illustrate these seven-year trends.





CHIP/SMHB GOAL 3

GOAL 3

Promote wellness and prevention

Ultimately, providing health insurance to children and unborn children is expected to result in enhanced access to preventive care. This preventive care should, in turn, promote and impact wellness and overall health outcomes. In reviewing whether CHIP and SMHB coverage has furthered DSS' goal of promoting wellness and prevention activities, it is insightful to review the results of certain HEDIS measures. In addition, as required by statute, the discussion under Goal 3 also addresses the impact of CHIP on providing a comprehensive array of community-based wraparound services for seriously emotionally disturbed (SED) children and children affected by substance use.

HEDIS Measures

HEDIS (Healthcare Effectiveness Data and Information Set) is a tool used by more than 90% of US health plans to measure performance on certain aspects of care and service.[27] DSS requires its managed care organizations (MCOs) to report on certain HEDIS measures, several of which are helpful to review when considering how DSS has made progress towards its goal of promoting wellness and prevention.

Missouri operates a Performance Withhold Program based on 14 HEDIS measures.[28] The program withholds three percent (3%) of the per-member per-month payment (PMPM) to the contracted managed care organizations. Payment is then released on an annual basis based on the health plan's improvement on the selected HEDIS measures. Due to the Coronavirus pandemic, the Performance Withhold Program will suspend the use of HEDIS measures in SFY 2021 and focus on quality improvement studies conducted by the managed care organizations.

DSS does not currently require that the results are stratified by Medicaid and CHIP, and so for this year's report the HEDIS information provided includes combined data for Medicaid and CHIP populations. While HEDIS includes a variety of measures, for purposes of this section of the report DSS is focusing on three specific measures: (i) well-child visits in the first 15 months of life, (ii) well-child visits between ages 3–6, and (iii) members age 2–20 with dental benefits who had at least one dental visit during the measurement year.

[27] *www.ncqa.org/hedis-quality-measurement*

[28] https://dss.mo.gov/business-processes/managed-care-2017/bidder-vendor-documents/managed-care-pwt-spec19.pdf

TABLE 14 HEDIS INFORMATION*

HEDIS MEASURE	HEDIS 2020	HEDIS 2019	HEDIS 2018	HEDIS 2017	HEDIS 2016
Percent of members with six or more well-child visits in the first 15 months of life	61.3%	55.9%	61.8%	57.2%	57.6%
Percent of members with well-child visits between ages 3–6	58.1%	58.6%	65.7%	61.9%	64.5%
Percent of members age 2–20 with dental benefits who had at least one dental visit during the measurement year	55.3%	49.5%	45.0%	46.9%	47.9%

**The HEDIS Measure year includes data from the previous calendar year. For example, HEDIS 2020 reflects data from calendar year 2019.*

Community-Based Wraparound Services for SED Children and Children Affected by Substance Abuse

Wraparound 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. Wraparound 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 (MHD) have developed joint protocols and guidelines for the provision of wraparound services. Funding is provided by a combination of state general revenue (DMH) and federal match dollars (MHD). DMH coordinates and oversees the delivery of these services.

DSS and DMH data on CHIP program eligibility, MCO enrollment and wraparound service utilization for CY 2019 were used for the purpose of this analysis. However, beginning in July 2017, DMH received a grant for a demonstration project that involved significant change to how services are reimbursed. As a result, payment for many services went from a FFS model to a bundled per diem payment. As the project is still relatively new, processes for the reporting of discreet service utilization within the bundled per diem are still under development.

There were 165 unique children in the CHIP program population who received wraparound services during the CY 2019.

While the MCOs are not required by contract to provide wraparound services, they often do so when it is cost effective as an alternative to more intensive levels of care. Still, the average child receiving FFS wraparound services received slightly more services than the average child receiving MC wraparound services, as illustrated in Table 16 below. Overall, based on the data received, FFS and MC children received more wraparound services in the second half of CY 2019. Figure 4 below shows how the mix of services differed for the time period of CY 2019 between the FFS and MC populations.

The statistics below, while informative, cannot be used on their own to determine the quality of wraparound services received by each population. There may be variances in each. Missouri continues to work with the Certified Community Behavioral Health Organizations (CCBHO) involved in the demonstration project to improve their claims data related to wraparound services. The data reflected in the below charts does not include CCBHO data at this time.

Tables 15 and 16 show utilization rates of wraparound services by type for CY 2019.

TABLE 15 QUANTITY OF WRAPAROUND SERVICE UNITS

WRAPAROUND SERVICES	TIME PERIOD	FAMILY SUPPORT	OTHER CASE MANAGEMENT	RESPITE	TARGETED CASE MANAGEMENT	OTHER WRAPAROUND SERVICES	COMMUNITY SUPPORT SERVICES
FFS	1/2019 – 6/2019	17	32	0	5	2	4,691
	7/2019 – 12/2019	8	53	0	37	7	5,569
MCO	1/2019 – 6/2019	432	87	0	131	13	15,259
	7/2019 – 12/2019	651	109	0	28	10	15,405

TABLE 16 WRAPAROUND SERVICE UNITS PER CHILD

WRAPAROUND SERVICES	TIME PERIOD	FAMILY SUPPORT	OTHER CASE MANAGEMENT	RESPITE	TARGETED CASE MANAGEMENT	OTHER WRAPAROUND SERVICES	COMMUNITY SUPPORT SERVICES
FFS	1/2019 – 6/2019	0.4	0.7	0	0.1	0	98.8
	7/2019 – 12/2019	0.1	0.9	0	0.7	0.1	98.2
MCO	1/2019 – 6/2019	2.7	.5	0	.8	0.1	95.9
	7/2019 – 12/2019	4	0.7	0	.2	0.1	95.0

Data Source: DMH wraparound claims data

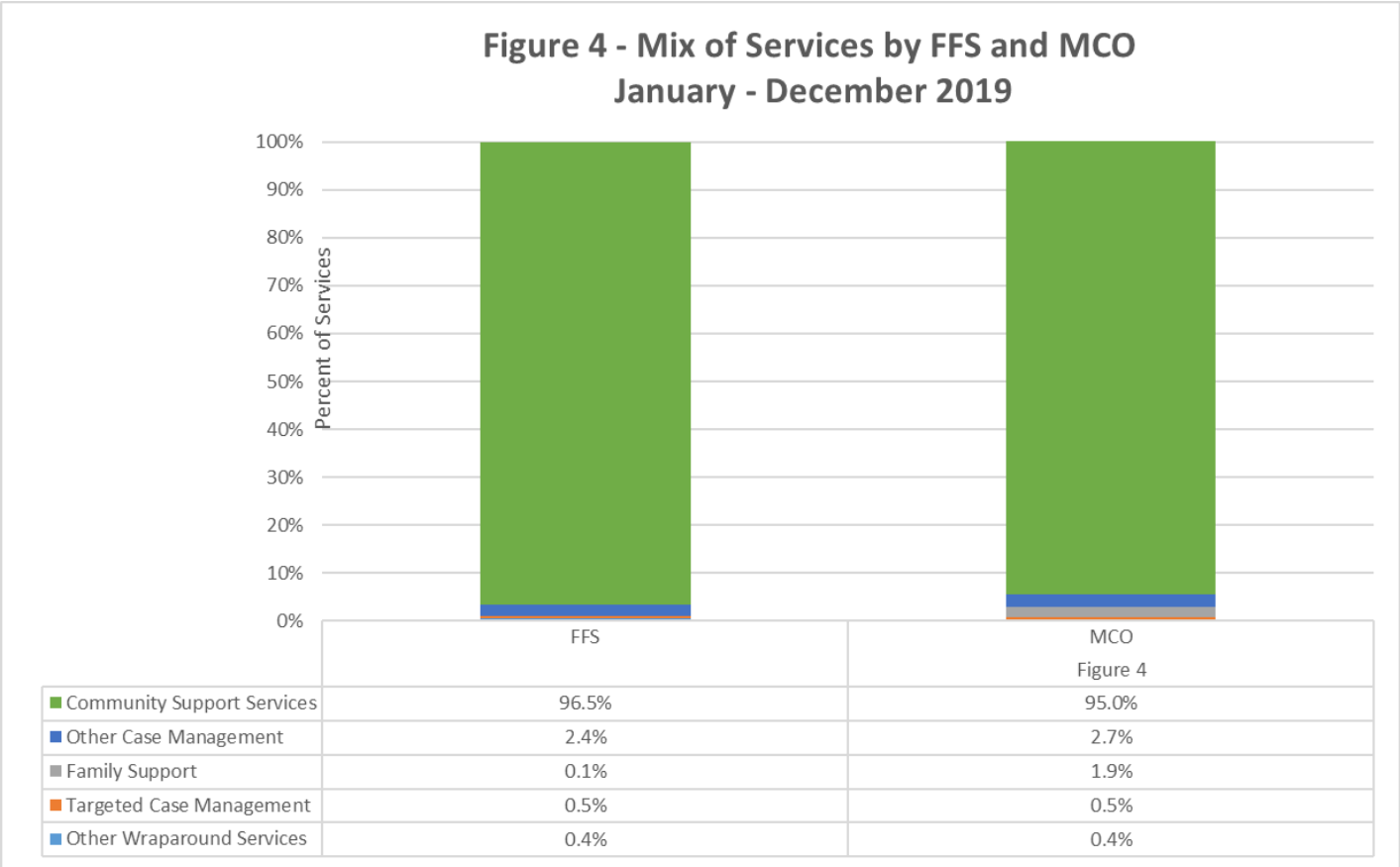


Figure 4

	FFS	MCO
Community Support Services	96.5%	95.0%
Other Case Management	2.4%	2.7%
Family Support	0.1%	1.9%
Targeted Case Management	0.5%	0.5%
Other Wraparound Services	0.4%	0.4%

Data Source: DMH wraparound claims data

CHIP/SMHB GOAL 4

GOAL 4

Ensure cost effective utilization of services

As stated in the QIS, cost-effective utilization of services is critical to the Department's ability to meet its mission of building the capacity of individuals, families and communities to secure and sustain healthy, safe and productive lives. In evaluating cost-effective utilization of services, DSS reviewed data around preventable hospitalizations, emergency department utilization, SFY 2019 expenditures for CHIP and SMHB, and select HEDIS measures.

Preventable Hospitalization Summary

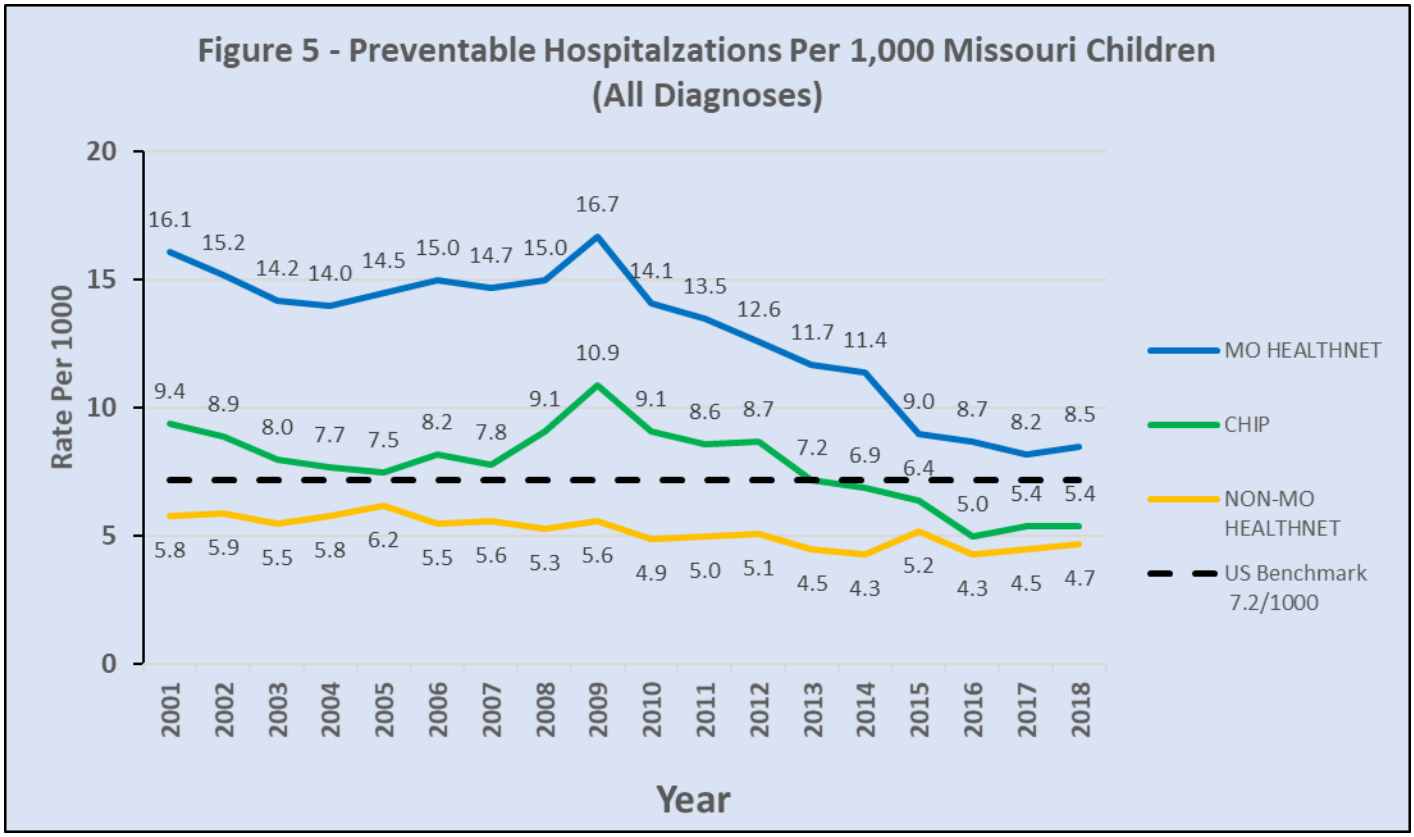
The data presented below looks at four hospital indicators including emergency department use and hospitalizations. For CY 2018, three of the four indicators saw very small increases when comparing 2017 to 2018, however, all four indicators remain below national benchmarks (lower scores are better).

Preventable Hospitalizations

From 2001 to 2018, preventable hospitalizations for the CHIP population decreased by 43%. During these time, preventable hospitalizations for the MO HealthNet (Medicaid children) population decreased by 50% while the preventable hospitalizations for the non-MO HealthNet group (children in Missouri who are not on Medicaid or CHIP) decreased by 23%.

In 2018, the CHIP population's preventable hospitalizations per 1,000 children was 5.4, which is approximately 25% below the national benchmark of 7.2 per 1,000.

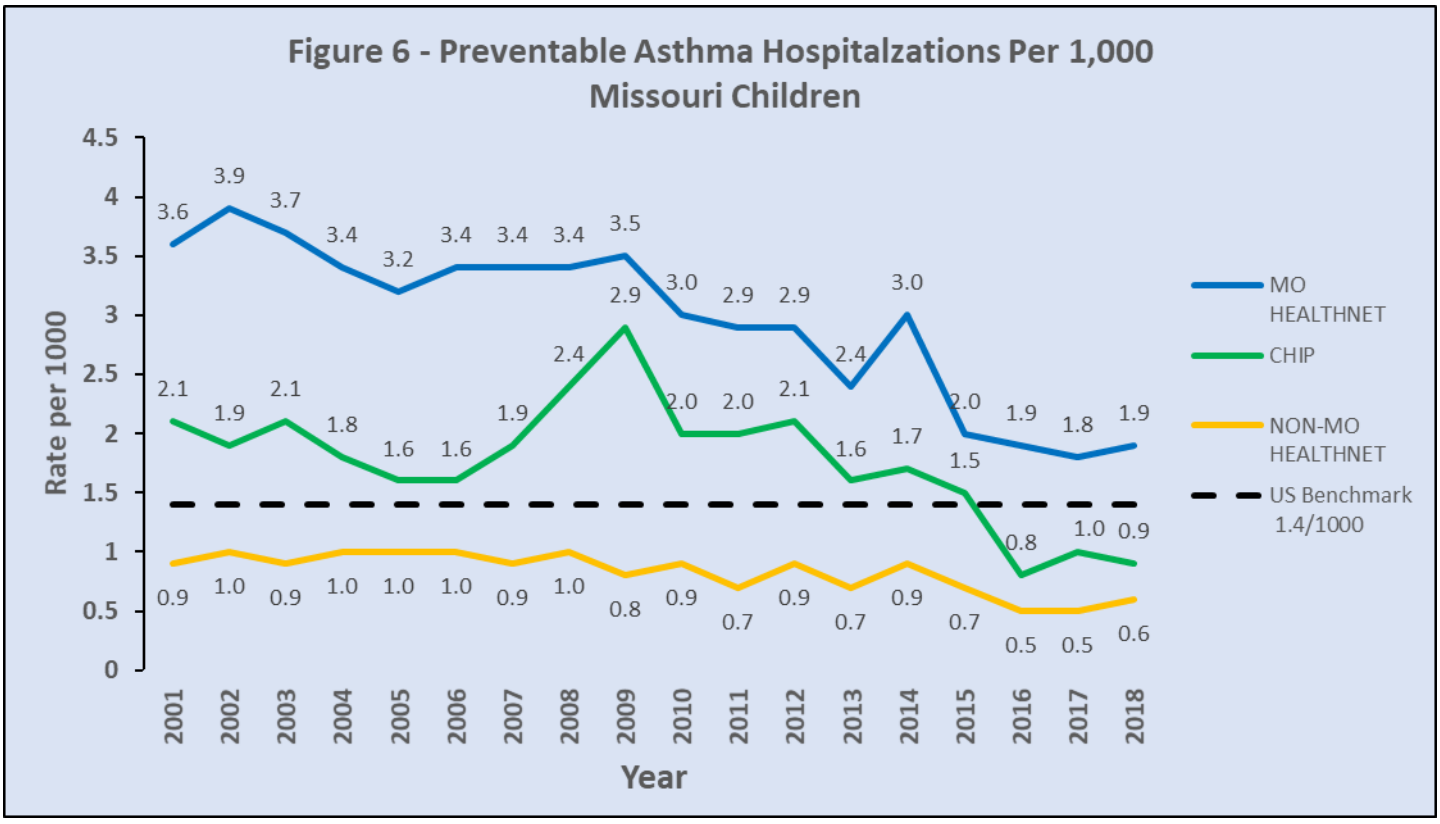
Notably, the MO HealthNet preventable hospitalizations rates continue to reduce over time and move closer to the non-MO HealthNet population preventable hospitalization rates.



Data Source: DHSS Health Status Indicator Rates

Preventable Asthma Hospitalizations

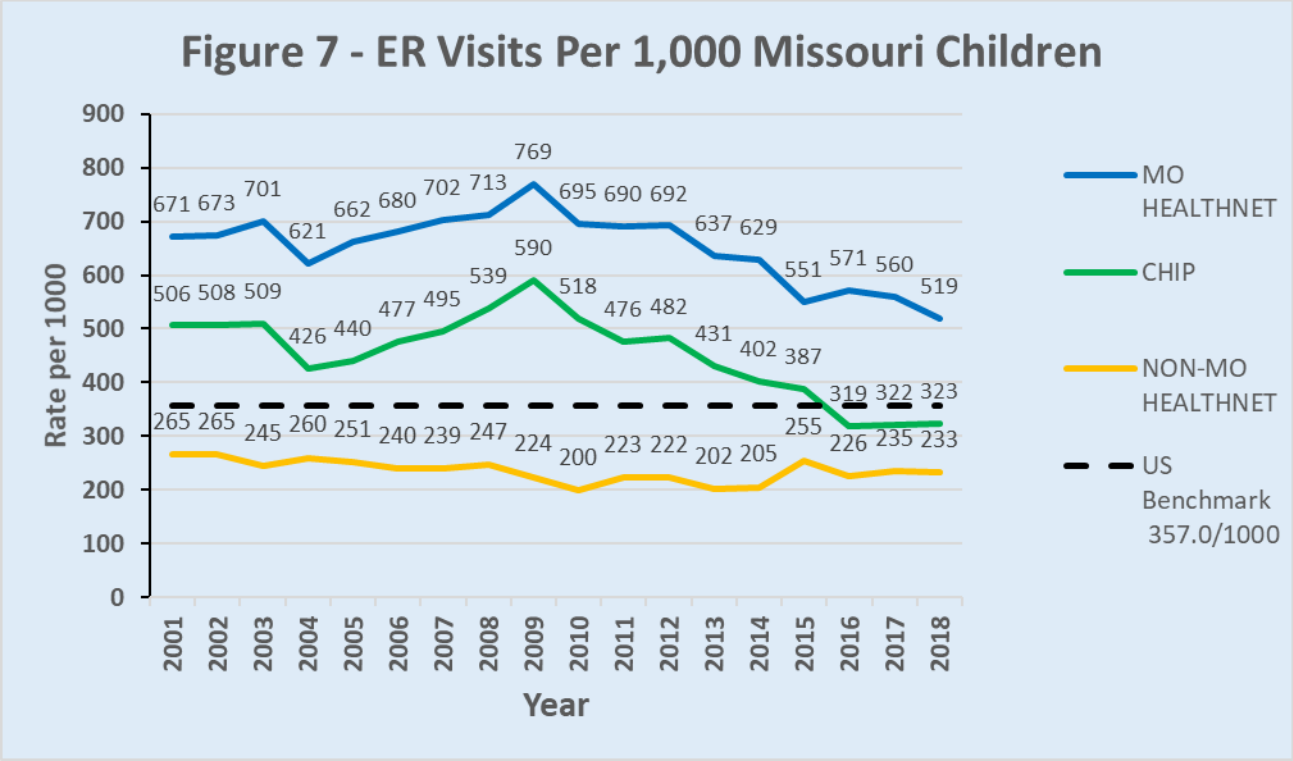
Since 2014, preventable hospitalizations due to asthma has decreased for the CHIP population. In 2018, the CHIP group's rate of 0.9 preventable asthma hospitalizations per 1,000 children was 36% lower than the national benchmark rate of 1.4 preventable asthma hospitalizations.



Data Source: DHSS Health Status Indicator Rates

Emergency Department Visits

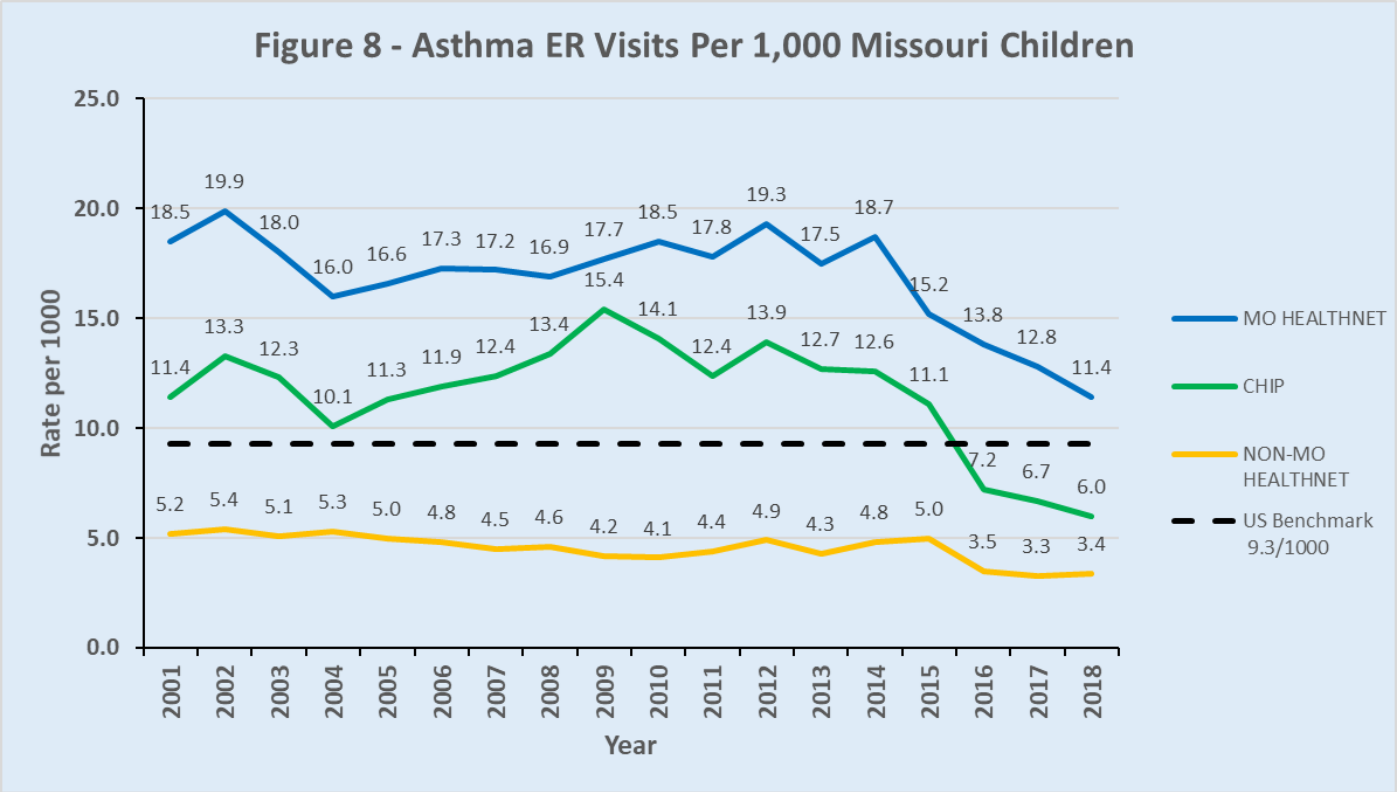
In 2018, the CHIP group's rate of 323 emergency department visits per 1,000 children was 10% lower than the national benchmark rate of 357 emergency department visits. Notably, the CHIP program has seen a decrease of 36% from 2001 to 2018 in emergency department visits. Over the same time period, emergency department visits decreased by 23% for the MO HealthNet (Medicaid children) population and by 12% for the non-MO HealthNet group (children in Missouri who are not on Medicaid or CHIP).



Data Source: DHSS Health Status Indicator Rates

Asthma Emergency Department Visits

In 2018, the continuation of asthma emergency department visits for the CHIP population was lower than the national benchmark rate. Missouri continues to see a substantial decline in this area. The CHIP 2018 rate of 6.0 asthma emergency department visits per 1,000 children was 35% lower than the national benchmark rate of 9.3 visits per 1,000 children.



Data Source: DHSS Health Status Indicator Rates

A summary of the below indicators from 2018 is presented in Table 17. Detailed data by region and by year is included as Appendix 4 of this report. In 2018, MO HealthNet implemented an asthma education and in-home environmental assessment program for youth with uncontrolled asthma. This program helps to further reduce ER utilization among the targeted population.

TABLE 17 SUMMARY OF 2018 INDICATORS FOR MISSOURI CHILDREN UNDER AGE 19 PER 1,000 CHILDREN

	CHIP	MO HEALTHNET (MEDICAID)	NON-MO HEALTHNET (NON-MEDICAID)	NATIONAL BENCHMARK
Preventable Hospitalizations	5.4	8.5	4.7	7.2
Preventable Asthma Hospitalizations	0.9	1.9	0.6	1.43
Emergency Department Visits	322.6	518.6	232.9	357.0
Asthma Emergency Department Visits	6.0	11.4	3.4	9.3

Rates are per 1,000 population. For non-CHIP population, age is under 18.
Data Sources: DHSS

CHIP and SMHB Expenditures

CHIP and SMHB are funded through federal and State appropriations (both through general State revenue and other State agency dollars). The State share, however, is a small fraction of the total CHIP expenditures in Missouri.

TABLE 18 CHIP SFY 2019 EXPENDITURES

	CHIP	SMHB	GRAND TOTAL
State General Revenue	$19,585,938.33	$9,481,771.10	$29,067,709.43
Other Funds	$7,719,204	$0	$7,719,204
Federal Funds	$86,613,163.44	$29,904,740.31	$116,517,903.75
Total	**$113,918,305.77**	**$39,386,511.41**	**$153,304,817.18**

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

CHIP/SMHB GOAL 5

GOAL 5

Promote member satisfaction with experience of care

The last goal of the QIS is to promote member satisfaction with experience of care. While not required by statute, an important indicator of the success of the CHIP and SMHB programs is reviewing member satisfaction with experience of care. If members do not have positive interactions with the health care system, they may be less likely to participate in preventive care, which could result in later increased costs (e.g., through unnecessary hospital visits). To that end, the Department reviewed available CAHPS data and compared results with national standards.

CAHPS results for four indicators related to satisfaction with experience of care are included in Table 19. Results for Missouri's CHIP program show that Missouri is above the national averages with respect to satisfaction related to actual providers and satisfaction with the child's health plan.

TABLE 19 CAHPS SATISFACTION WITH EXPERIENCE OF CARE RESULTS AMONG CHIP PARTICIPANTS

CAHPS MEASURE	MISSOURI CHIP	NATIONAL HMO AVERAGE
Proportion of respondents that would rate all their child's health care in the last six months an 8 or higher on a scale from 0-10 where 0 is the worst health care possible and 10 is the best health care possible.	92.33%	75.35%
Proportion of respondents that would rate their child's personal doctor an 8 or higher on a scale from 0-10 where 0 is the worst personal doctor possible and 10 is the best personal doctor possible.	93.07%	77.56%
Proportion of respondents that would rate their child's specialist seen most often an 8 or higher on a scale from 0-10 where 0 is the worst specialist possible and 10 is the best specialist possible.	87.93	82.1%
Proportion of respondents that would rate their child's health plan an 8 or higher on a scale from 0-10 where 0 is the worst health plan possible and 10 is the best health plan possible.	88.93%	82.29

CONCLUSION

CHIP AND SMHB: INVESTING TODAY IN MISSOURI'S FUTURE

It has been two decades since Missouri adopted its CHIP program. While the program has evolved over the years, one stalwart outcome has been greater access to health care for Missouri's children who otherwise would not have coverage—public or private. Although the rate of uninsured increased by 0.6% nationally in 2018, progress has been made in improving health outcomes for children enrolled in the program. Satisfaction with the program is also high among participants.

On July 1, 2019, Centers for Medicare and Medicaid (CMS) awarded 39 cooperative agreements in 25 states. Up to $48 million was made available from the Helping Ensure Access for Little Ones, Toddlers and Hopeful Youth by Keeping Insurance Delivery Stable Act (Healthy Kids Act). Missouri was one of those awardees to enroll and retain eligible children in Medicaid and CHIP.[29]

Improved health outcomes realized through CHIP and SMHB all has been done with stewardship of public resources; greater access to preventive care has helped children avoid emergency rooms and hospital stays. The data indicates that CHIP has not replaced private insurance coverage but rather fills a coverage gap for working families.

Longer-term health and financial benefits, as supported by the cited research, should also be considered in summarizing the impact of CHIP and SMHB in Missouri. Emerging evidence has suggested that greater access to health care coverage earlier in life supports long-term health, academic, and employment outcomes. These long-term outcomes of early access to care are especially promising in light of the relatively recent adoption of the SMHB program. Prenatal care provided through SMHB is already improving birth outcomes. With continued support, the potential for other lifetime outcome improvements is exponential.

[29] https://www.insurekidsnow.gov/

APPENDICES

APPENDIX 1: CHIP PREMIUMS

APPENDIX 2: MEDICAID AND CHIP ENROLLMENT BY COUNTY (EXCLUDES SMHB)

APPENDIX 3: SMHB ENROLLMENT BY COUNTY

APPENDIX 4: HOSPITALIZATION AND ER UTILIZATION RATES BY PAYER/PROGRAM (2001–2018)

APPENDIX 5: DMH-DSS WRAPAROUND SERVICE CODES AND TITLES

SEE SEPARATE DOCUMENT