Hospital Guidance for

Promoting Enrollment and Reimbursement for

Missouri Medicaid Expansion Adults

Updated October 14, 2021

Updated material in this release is shown in red font.

This document will be updated as new information about the implementation of coverage under Missouri's Medicaid expansion becomes available. Watch for occasional updates. Please send requests for additional information or clarifications to Brian Kinkade at bkinkade@mhanet.com.

MISSOURI'S MEDICAID EXPANSION

When Missouri's Medicaid expansion becomes effective, more than 274,000 low-income, non-disabled adults with incomes below 138% of the federal poverty level are expected to become eligible for coverage under Medicaid expansion.

These "expansion adults" must apply and be found eligible by the Department of Social Services Family Support Division for coverage under the new Medicaid expansion to begin. For those eligible, coverage becomes effective on the first day of the month that the application was filed. Upon request and for those who qualify, Missouri Medicaid will pay for the allowable medical services newly covered participants received in the three months before their initial Medicaid coverage begins. In the case of individuals qualifying under Medicaid expansion, this "prior quarter coverage" only can go back to July 1, 2021, the effective date for Medicaid expansion set by the Missouri Constitution.

Various scenarios showing when coverage would be effective under different scenarios of expansion effective dates and patient application dates are shown on the following page.

MEDICAID EXPANSION APPLICATION AND COVERAGE SCENARIOS

In this scenario, Medicaid expansion becomes effective July 1. A patient that applies for expansion coverage in September and is approved, will have coverage beginning September 1. If the patient requests prior quarter coverage and is eligible for those months, medical expenses he/she incurred in July and August are reimbursable as well. However, prior quarter coverage can go back no further than the implementation date of expansion coverage.

In this scenario, a patient that applies for expansion coverage in November and is approved, will have coverage beginning November 1. If the patient requests prior quarter coverage and is eligible for those months, medical expenses he/she incurred in August, September and October are reimbursable as well.

This primer provides strategies hospitals may want to pursue to increase the likelihood that the newly Medicaid eligible patients they care for enroll in the coverage to which they are entitled, so the health care they receive can be reimbursed.

Section 1 discusses the application process and actions hospitals can take to encourage Medicaid enrollment. Section 2 discusses reimbursement for services provided to expansion adults. Section 3 provides answers to "frequently asked questions" related to the Medicaid expansion and the MO HealthNet application process.

SECTION 1: MEDICAID EXPANSION PATIENT ENROLLMENT STRATEGIES

Expansion eligible adults must be determined by DSS FSD to meet income, citizenship and residency standards for coverage to begin. Eligibility standards for expansion adults are the same modified adjusted gross income or "MAGI" standards that have been used for MO HealthNet parents and children since 2014. The same application used for parents and children currently will be used for expansion adults applying for coverage.

Hospitals are uniquely positioned to promote and facilitate Medicaid enrollment for their patients. Hospitals should be aware of the enrollment strategies and resources summarized below and discussed in detail on the following pages.

Identify and Educate Potentially Eligible Patients

- Track or identify and follow up with patients who are potentially eligible for expansion coverage and who have received hospital care since July 1, 2021. Encourage them to apply for Medicaid coverage as soon as possible. Explain to these patients that in their application they need to state that they want assistance with medical expenses for the 3 months before their coverage date. (See FAQ #11 – Prior Quarter Coverage.)

Actively Assist Patients Applying for Medicaid Coverage

- Work directly with the enrollee to complete an application, including a prior quarter coverage request.
- Actively manage the patient's application as his or her authorized representative and submit the application (with prior quarter coverage request) on his or her behalf.
- With FSD approval, hospitals may issue presumptive eligibility determinations to secure payment for services provided while a patient's regular Medicaid application is being processed.

Strategy 1 — Identify and Educate Patients Who Are Potentially Eligible for Expansion Coverage

Hospitals should consider identifying, flagging, and tracking uninsured or underinsured and underinsured adult patients with modest household incomes who have been treated since July 1. Hospitals may wish to contact these patients to encourage them to apply for Medicaid expansion coverage. See the Application Assistance section that begins on page 6 for additional details on the applications process and what role hospitals can play in helping patients apply for coverage.

When and Where Applications Can Be Filed

The court order issued August 10 clears the way for expansion-eligible Missourians to immediately begin applying for Medicaid coverage. At the time of this writing, it is unclear how quickly DSS FSD will process these applications and actually enroll eligible individuals in coverage. However, individuals, once approved and enrolled, will have coverage from first day of the month in which their application was received by DSS FSD.

Hospitals can direct potentially eligible patients to the DSS portal to apply online at MyDSS.mo.gov or to obtain paper applications which can be filed by email, mail or fax. Applicants will need their Social Security number, information on their income from current paystubs and information about any health insurance coverage they currently have.

Important: Individuals may have other health insurance coverage and still qualify for Medicaid coverage. It is not necessary for an individual to be uninsured to have Medicaid coverage.

Applicants who are parents should be sure to provide information about their children and their children's health insurance coverage. The parent can qualify for coverage under the Medicaid expansion only if his or her child(ren) is(are) covered or applying for coverage on the parent's application. The applicant's child(ren) can be covered by Medicaid or commercial insurance that meets the Affordable Care Act's Minimum Essential Coverage standards. (See FAQ # 1 – Who is eligible for Medicaid expansion.)

Once submitted, one should expect DSS FSD to take 30 to 45 days to process the application, although the process can take longer if FSD requires additional documentation to verify income, citizenship, residency, etc. **Applicants should be alert for mail from FSD requesting additional documentation to verify their eligibility.** If the applicant fails to respond to the request in a timely manner, the application will be rejected. Authorized representatives will receive these requests for additional documentation on behalf of the applicant.

Processing of applications received before October 1 will not be completed until October 1. Applicants who are eligible for coverage will not be enrolled before October 1. However, once enrolled, eligible applicants will have coverage back to the first day of the month of application – either August 1 or September 1. For those applying for coverage before October 1, FSD will automatically assess the applicant's eligibility for retroactive coverage (prior quarter coverage) back to July 1. Individuals applying after October 1 must request prior quarter coverage specifically when they apply. (See FAQ #11 — Prior Quarter Coverage.)

Educating Patient Applicants About Prior Quarter Coverage
Most importantly, hospitals that have treated patients before they apply for Medicaid coverage should direct the patient to indicate in their Medicaid application that they want assistance with medical expenses in the previous three months. Making this explicit request is necessary for the applicant to be assessed for Prior Quarter Coverage, which may allow the hospital to be reimbursed by MO HealthNet for services provided before the patient was able to apply for coverage. (See FAQ #11 — Prior Quarter Coverage.)

Until October 1, 2021, FSD will automatically assess eligibility for prior quarter coverage for all expansion eligible adults. After October 1, FSD will only assess prior quarter coverage eligibility if the applicant says they want assistance with medical expenses in the three previous months.

Hospitals only can be reimbursed for care provided to newly enrolled patients before the effective date of their coverage if the patient requests prior quarter coverage. Prior quarter coverage can be requested at the time of the initial application or within the first 12 months of Medicaid coverage.

Outreach and Education Materials

The Missouri Foundation for Health has a variety of Medicaid expansion outreach and educational materials available to hospitals and other health care advocates, including a Medicaid Expansion Message Guide and a social media tool kit.

Additional information about Missouri Medicaid, and resources available to support Missourians applying for coverage are available at the Foundation's Cover Missouri website.

Membership in the Cover Missouri Coalition is free and open to all. Membership provides access to news updates, education sessions and advocacy materials on health care coverage available through the state's MO HealthNet program and the federal marketplace (Obamacare). Contact Heather Lasher Todd of StratCommRx for more information or to join the group.

Community-based Enrollment Support
Local entities that have trained "assisters" are available to help any individual apply for Medicaid. A locater tool found at the HealthCare.gov website will direct individuals seeking help to assisters nearby. Input the patient's zip code and hit "enter." On the subsequent results page, select "Medicaid and CHIP" from the pull-down menu to see Medicaid application assisters in the area. The MHF provides a similar tool its Cover Missouri website.

Healthcare.gov
Missourians who apply for health care coverage through the Federally Facilitated Marketplace FFM) at Healthcare.gov are screened for their eligibility for Medicaid coverage though MO HealthNet. The FFM will transfer the application of those appearing to qualify for Medicaid directly to the DSS FSD. The FSD will process this "account transfer" as it would any application for MO HealthNet coverage.

Although Missouri Medicaid eligible individuals who apply through Healthcare.gov will ultimately have their application redirected to DSS FSD, hospitals assisting patients applying for MO HealthNet coverage are strongly encouraged to apply directly through the state's portal at MyDSS.mo.gov. Persons applying for coverage with DSS FSD who are found to be ineligible for MO HealthNet coverage will have their application redirected automatically to the FFM to determine their eligibility for subsidized (Obamacare) coverage.

Monitoring Eligibility Status

Hospitals can monitor the eligibility status of these patients through the department's online provider portal, eMOMED. Once the patient's eligibility is established and they are enrolled in managed care plan, the hospital will be able to bill for reimbursement in the same manner as other MO HealthNet covered patients.

Hospitals also may request query access to the state's Medicaid case management systems FAMIS and MEDES, to check an individual's eligibility and application status. Requests for access should be sent to Brian Kinkade, MHA's Vice President of Children's Health and Medicaid Policy at bkinkade@mhanet.com with the following information:

1. Legal (Doing Business As) name of the hospital,
2. Hospital's official mailing address (for contracting purposes),
3. Name of the hospital official authorized to sign the requisite agreements for access to be granted, and
4. Name and email address and phone number of the hospital employee coordinating the hospital's request.

Kinkade will forward the hospital's request and related information to DSS. The DSS Division of Financial Services (DFAS) will provide the hospital with system access agreements for MEDES and/or FAMIS for signature by the hospital's contract official. Once the signed agreement(s) is(are) returned, FSD will coordinate a security review of the hospital's information systems, obtain the technical data required to upload the programs, and return executed agreements to the hospital.

Patients with Federally Facilitated Marketplace Coverage (Obamacare) Patients with incomes between 100% and 138% FPL with health insurance purchased through the FFM will be eligible for MO HealthNet Medicaid coverage under the expansion. These patients may choose to keep their marketplace subsidized coverage through the end of the calendar year 2021 without penalty. Those retaining their marketplace coverage will be responsible for paying any premiums and copayments associated with their policy. Those wishing to drop their marketplace coverage to enroll in Medicaid may do so.

Beginning in January 2022, individuals between 100% and 138% FPL who qualify for Medicaid coverage as an expansion adult no will longer qualify for subsidized coverage through the FFM.

Strategy 2 — Actively Assist Patients Applying for Medicaid Coverage

Beyond supplying information, hospitals may begin or continue their direct engagement to help applicants secure coverage by having hospital staff assist patients complete their applications or by being authorized to complete and file Medicaid application on the patient's behalf.

Hospital employees who act on behalf of the patient in filing a Medicaid application must be designated as an authorized representative by the patient (See FAQ #14 — Authorized Representatives). Once designated, an authorized representative will receive all communications from the state related to the patient's application and requests from the state for documentation needed for the state to determine eligibility. It would be the authorized representative's duty to respond to state's communications in a timely manner. Authorized representatives must be a person; the hospital cannot be designated as the patient's authorized representative.

Note, however, the authorized representative designation only is needed if the hospital employee will actively manage the patient's application. A hospital employee **does not** need to be designated as an authorized representative to simply help a patient complete the Medicaid application.

Applications Process

Hospital personnel who are familiar with the current MO HealthNet application process for children and parents will recognize it as the one used for expansion adults. The modified adjusted gross income or "MAGI" eligibility standard that is used for parents and children today is the same standard that will be used to determine eligibility for expansion adults.

The regular MO HealthNet application process is used for individuals applying for expansion coverage.

Applying online is preferred and most expeditious, but several other options are available:

- Online: MyDSS.mo.gov
- Phone: 855-373-9994
- Email: FSD.Documents@dss.mo.gov
- U.S. Mail: Family Support Division, 615 E 13th St., Kansas City MO 64106
- Fax: 573-526-9400

Paper applications that can be mailed, emailed or faxed are available in fillable PDF and printable formats.

Applicants will need their Social Security number, information on their income from current paystubs and information about any health insurance coverage they currently have.

IMPORTANT: Individuals may have other health insurance coverage and still qualify for Medicaid coverage. It is not necessary for an individual to be uninsured to have Medicaid coverage.

An individual seeking coverage who is the parent of a child who is already covered by MO HealthNet may simply complete an "Add-a-Person" form, instead of completing a full new application. This action can be done several ways:

- Online: Report a Change
- Phone: 855-373-9994
- U.S. Mail: Family Support Division
  615 E. 13thStreet
  Kansas City, MO 64106
- In person: Visit a local Resource Center.

Once submitted, one should expect DSS FSD to take 30 to 45 days to process the application, although the process can take longer if FSD requires additional documentation to verify income, citizenship, residency, etc. **Applicants should be alert for mail from FSD requesting additional documentation to verify their eligibility.** If the applicant fails to respond to the request in a timely manner, the application will be rejected. Authorized representatives will receive these requests for additional documentation on behalf of the applicant.

Once approved and enrolled, individuals will have coverage from first day of the month in which their application was received by DSS FSD.

Processing of applications received before October 1 will not be completed until October 1. Applicants who are eligible for coverage will not be enrolled before October 1. However, once enrolled, eligible applicants will have coverage back to the first day of the month of application – either August 1 or September 1. For those applying for coverage before October 1, FSD will automatically assess the applicant's eligibility for retroactive coverage (prior quarter coverage) back to July 1. Individuals applying after October 1 must request prior quarter coverage specifically when they apply. (See FAQ #11 — Prior Quarter Coverage.)

Women who applied for and/or were approved for coverage under the limited-benefit Women's Health Program prior to July 1 may request to evaluated for eligibility for full coverage as an expansion adult. A new application is not needed. The participant may call the FSD call center at 855-373-9994 and request to be evaluated for adult expansion coverage. Hospitals can request the change through FSD.MEDESUSERS@dss.mo.gov. Women applying for the limited benefit program after July 1 will automatically be reviewed for eligibility under the adult expansion criteria.

Prior Quarter Coverage

If the hospital already has provided care to the patient applying for expansion coverage, ensure the patient indicates on their Medicaid application they want assistance with medical expenses in the previous three months. This request is necessary for the applicant to be assessed for Prior Quarter Coverage, which may allow the hospital to be reimbursed by MO HealthNet for services provided before the patient was able to apply for coverage. (See FAQ #11 — Prior Quarter Coverage.)

Hospitals only can be reimbursed for care provided to newly enrolled patients before the effective date of their coverage if the patient requests prior quarter coverage. Prior quarter

coverage can be requested at the time of the initial application or within the first 12 months of Medicaid coverage.

Until October 1, 2021, FSD will automatically assess eligibility for prior quarter coverage for all expansion eligible adults. After October 1, FSD will only assess prior quarter coverage eligibility if the applicant says they want assistance with medical expenses in the three previous months.

Presumptive Eligibility

Hospitals authorized by the DSS FSD to do so may complete presumptive eligibility for qualifying patients. (See FAQ #13 – Presumptive Eligibility.) Presumptive eligibility allows for the hospital to establish temporary Medicaid eligibility to enable the delivery of and payment for services while a patient's eligibility for regular Medicaid coverage is being determined. Submission of an application for regular Medicaid coverage is required.

Presumptive Eligibility coverage ends once the patient's Medicaid application is processed, or the last day of the month following the month the presumptive eligibility determination was made if no application is filed.

Monitoring Eligibility Status

Hospitals can monitor the eligibility status of these patients through the department's online provider portal, eMOMED. Once the patient's eligibility is established and they are enrolled in managed care plan, the hospital will be able to bill for reimbursement in the same manner as other MO HealthNet covered patients.

Hospitals may also request access to the state's Medicaid case management systems FAMIS and MEDES, to check an individual's eligibility and application status. Requests for access should be sent to Brian Kinkade, MHA's Vice President of Children's Health and Medicaid Policy at bkinkade@mhanet.com with the following information:

1. Legal (Doing Business As) name of the hospital,
2. Hospital's official mailing address (for contracting purposes),
3. Name of the hospital official authorized to sign the requisite agreements for access to be granted, and
4. Name and email address and phone number of the hospital employee coordinating the hospital's request.

Kinkade will forward the hospital's request and related information to DSS. The DSS Division of Financial Services (DFAS) will provide the hospital with system access agreements for MEDES and/or FAMIS for signature by the hospital's contract official. Once the signed agreement(s) is(are) returned, FSD will coordinate a security review of the hospital's information systems, obtain the technical data required to upload the programs, and return executed agreements to the hospital.

SECTION 2: REIMBURSMENT FOR MEDICAID EXPANSION ENROLLEES

Once an individual applies and is determined eligible for coverage under the MO HealthNet expansion, hospitals may bill for allowable covered services as they would for any other MO HealthNet covered patient. Expansion eligible adults will be covered through the MO HealthNet managed care program and will be enrolled with one of the state's three Medicaid managed care plans.

MO HealthNet has not yet issued specific payment directives related to the expansion population. The guidance herein is based on MHA's assumption that payment policies will be the same as those governing MO HealthNet participants who receive their care through managed care today.

This guidance will consider reimbursement under the three different coverage conditions hospitals will encounter. These conditions are summarized below and discussed further in the following pages.

Eligible Individuals Covered Currently and Prospectively

- Individuals qualifying for coverage under the Medicaid expansion will receive their care through managed care and will be enrolled in one of the three existing managed care plans that currently serve MO HealthNet parents and children. Payment for services will be made by the plan with which the individual is enrolled.

Eligible Individuals Covered Retroactively (prior quarter coverage)

- Individuals qualifying for prior quarter coverage are expected to have the allowable care they received during their period of retroactive eligibility reimbursed under the fee-for-service program (not managed care). This is the current policy for MO HealthNet managed care enrollees. (See FAQ #11 — Prior Quarter Coverage.)

Eligible Individuals Not Covered

- Costs to treat patients who are eligible for expansion coverage but who do not apply can be tagged and reported for Medicaid DSH reimbursement in the usual manner.

Reimbursement of Services for Eligible Individuals Covered Currently and Prospectively

Expansion Adults Will be Enrolled in Managed Care

Newly eligible Medicaid expansion adults will be automatically assigned to one of the three existing MO HealthNet managed care plans: Home State (Centene), United Community Health Plan (United Healthcare) or Healthy Blue (Anthem). Newly enrolled patients have 90 days from the date they are enrolled in a managed care plan by MO HealthNet's enrollment broker to change their plan. Changes in this first 90 days can be made without cause online, by completing and submitting this form or by calling the managed care enrollment broker at 800-348-6627.

At the time of this writing, MO HealthNet has issued no managed care directives specifically related to the expansion population. However, it is likely that services provided to these patients on and after the effective date of their coverage will be billed to the patients' managed care plan in the usual manner.

Covered Services

Covered services for Medicaid expansion adults are the same as for the existing patient groups covered by MO HealthNet. All covered services are paid through managed care with the exception of pharmaceuticals. Pharmaceuticals are paid on a fee-for-service basis by MO HealthNet.

Cost Sharing

MO HealthNet ended cost sharing (copayments, coinsurance, and deductibles) effective July 1, 2021. The same policy of no cost sharing also will apply to the adults covered under the Medicaid expansion.

Eligible Individuals Covered Retroactively (prior quarter coverage)

Individuals requesting assistance with recent health care expenses at the time they apply for Medicaid coverage may qualify for prior quarter coverage. Medicaid will reimburse health care services the newly enrolled participant received in the 90 days prior to the effective date of their Medicaid coverage. To qualify for prior quarter coverage, the participant must meet the eligibility criteria for Medicaid coverage throughout the prior quarter period.

Reimbursement of Services Delivered in the Prior Quarter Coverage Period

Participants eligible for prior quarter coverage are covered under the MO HealthNet fee-for-service program, even if the participant currently is enrolled with a Medicaid managed care plan. Hospitals filing claims for services delivered to a Medicaid-eligible participant during the prior quarter coverage period must submit claims to MO HealthNet. MO HealthNet fee for service limitations and reimbursement rates will apply.

Medicaid DSH to Recoupment When Potential Enrollees Forego Coverage

For patients who potentially are eligible for Medicaid expansion coverage but fail to apply for coverage, the costs of their care will continue to be eligible for reimbursement under the current Medicaid Disproportionate Share Hospital program. Reimbursement for the costs of treating the uninsured generally is delayed until the costs are captured in the third- or fourth-prior year cost report. Payment of DSH costs is a significant part of the Missouri Medicaid hospital payment system, but it is based on evolving factors such as federal payment limitations and the amount of uninsured care provided by other Missouri hospitals in a given fiscal year. DSH payments are not made for patients with any other source of coverage, even if that coverage is limited.

SECTION 3: FREQUENTLY ASKED QUESTIONS

1. **Who is eligible for the Medicaid expansion?**

Nondisabled adults age 19 to 64 with income at or below 138% of the federal poverty level are eligible for coverage under Missouri MO HealthNet's expanded Medicaid program.

Individuals **do not** have to be uninsured to qualify for Medicaid expansion coverage. Medicaid is secondary to any other health care coverage an individual has.

Parents should be aware of how their children will affect their eligibility for Medicaid expansion coverage. Children affect a parent's eligibility for expansion coverage in two ways. First, FSD will count as members of the parent-applicant's household the dependent child(ren) they claim for federal income tax. The household size is a factor in determining the income eligibility standard that will apply for the parent-applicant's eligibility (and the eligibility of his or her child(ren)). (See FAQ #2 Annual income relating to 138% FPL.) Second, if the parent-applicant is the primary caretaker (i.e., physical custodian) of his or her child(ren), the child(ren) must have health coverage for the parent-applicant to qualify. In this case, coverage means that the custodial parent's child(ren) is(are) enrolled in Medicaid or are enrolled in commercial insurance that meets the Affordable Care Act's standards for Minimal Essential Coverage (MEC). If the applicant's child(ren) is(are) uninsured, the parent-applicant should include the children in their application for Medicaid expansion coverage.

2. **What annual income equates to 138% FPL?**

Household Size	138% FPL — 2021 Guidelines (Annual Income)
1	$17,774
2	$24,040
3	$30,305
4	$36,570
5	$42,835

The income levels in the table above are based on the 2021 poverty guidelines. The guidelines are updated annually in February by the U.S. Department of Commerce.

3. **When does the expansion take effect?**

The constitutional amendment passed by voters sets July 1, 2021, as the effective date for Missouri's Medicaid expansion. An individual's coverage begins on the first day of the month in which their application for Medicaid coverage is received and registered by FSD. Newly enrolled expansion adults may be eligible for coverage for health care services received in the 90 days prior to their coverage date, however, the retroactive

(prior quarter) coverage cannot extend back further than July 1, 2021, since this is the official start date for Missouri's expansion.

4. **Can hospitals bill for services provided to an individual eligible for the Medicaid expansion now that the expansion has taken effect?**
   No, not immediately. Eligible citizens must apply, and the state must determine that the applicant is eligible before a qualifying individual is covered. The constitutional amendment passed by voters sets July 1, 2021, as the effective date for Missouri's Medicaid expansion. An individual's coverage begins on the first day of the month in which their application for Medicaid coverage is received and registered by FSD. Providers can only file claims for services delivered when a patient's coverage is in effect.

5. **Is the legal basis for Medicaid expansion in question?**
   No. The Missouri Supreme Court unanimously affirmed the legality of the Missouri's Medicaid expansion. Although some questions remain as to how the legislature budget for the costs of the Medicaid expansion, this issue will not stop the expansion from taking effect and coverage for eligible individuals from beginning.

6. **When can individuals eligible for the Medicaid expansion apply for coverage?**
   DSS FSD now is accepting applications from individuals who may be eligible under the Medicaid expansion. At the time of this writing, processing of applications for expansion eligible adults will be delayed until October 1 while the state updates its computer systems for the new coverage group. However, once processed and if approved, an individual's coverage will begin on the first day of the month in which their application was received by FSD.

7. **What is necessary for applicants for expansion coverage to be determined eligible for coverage?**
   The applicant must submit a completed application to the DSS and be determined to meet the eligibility criteria. Hospital staff can assist patients by providing applications (or links to the online application portal) and by helping patients complete their application. Applicants must know their Social Security number and current income. Current pay stubs are helpful, and oftentimes necessary documentation of the applicant's income.

8. **How long does it take the state agency to determine eligibility?**
   DSS typically takes 30 to 45 days to process an application and determine whether an applicant is eligible or ineligible for coverage. However, the application review process likely will take longer in the early days of expansion's implementation.

9. **How do I know if an individual has been determined eligible for coverage?**
   Current eligibility status of any MO Health Net participant can be found on MO HealthNet's eMOMED system. Hospital personnel with access to this system can check eligibility of a Medicaid expansion participant in the same way they would check eligibility status for any existing MO HealthNet covered individual.

Hospitals also may request access to the state's Medicaid case management systems FAMIS and MEDES, to check an individual's eligibility and application status. Requests for access should be sent to Brian Kinkade, MHA's Vice President of Children's Health and Medicaid Policy at bkinkade@mhanet.com with the following information:

1. Legal (Doing Business As) name of the hospital,
2. Hospital's official mailing address (for contracting purposes),
3. Name of the hospital official authorized to sign the requisite agreements for access to be granted, and
4. Name and email address and phone number of the hospital employee coordinating the hospital's request.

Kinkade will forward the hospital's request and related information to DSS. The DSS Division of Financial Services (DFAS) will provide the hospital with system access agreements for MEDES and/or FAMIS for signature by the hospital's contract official. Once the signed agreement(s) is(are) returned, FSD will coordinate a security review of the hospital's information systems, obtain the technical data required to upload the programs, and return executed agreements to the hospital.

10. If an individual's application is approved, when does their Medicaid coverage begin?

Once approved, an applicant's coverage becomes effective the first day of the month in which the application is received by the DSS. Payment for services on and after the coverage effective date is made by the managed care plan in which the participant is enrolled.

If an applicant requests and is found to be eligible for <u>prior quarter coverage</u>, MO HealthNet will reimburse allowable medical expenses the newly enrolled participant incurred during the three months prior to the effective date of their coverage. (See FAQ #11 – Prior Quarter Coverage.) Payment for services eligible for reimbursement during the prior quarter coverage period are made by MO HealthNet on a fee-for-service basis.

11. What is "prior quarter coverage" and what must applicants do to receive it?

Prior quarter coverage allows Medicaid to pay the cost of Medicaid allowable health care services the newly covered Medicaid participant received in the 3 months before their Medicaid coverage begins.

<u>This coverage does not happen automatically</u>, the applicant must request coverage of prior quarter expenses in the application. Further, the applicant must provide information on their income and eligibility status for the prior quarter; prior quarter coverage is available only if the applicant would have been eligible for Medicaid coverage in the prior quarter.

IMPORTANT NOTE: There is not a section in the MO HealthNet application that is called "Prior Quarter Coverage," and this phrase is not used in the application. The applicant is asked if he or she had medical expenses in the previous three months for which they want assistance. The applicant must answer this question "yes" for eligibility for prior quarter coverage to be assessed.

EXCEPTION: Until October 1, 2021, FSD will automatically assess eligibility for prior quarter coverage back to July 1 for all expansion eligible adults. After October 1, FSD will only assess prior quarter coverage eligibility if the applicant says they want assistance with medical expenses in the three previous months.

Prior quarter coverage does not have to be requested in the initial application. Medicaid participants have one year from the date of their initial coverage to request prior quarter coverage.

For individuals covered under the Medicaid expansion, prior quarter coverage only will go back to July 1, the official start date of Missouri's expansion coverage set by the constitution. See the Application and Coverage Scenarios on page 2.

In summary, there are three important points to know about prior quarter coverage:

i. Prior quarter coverage must be requested by the individual, or by his or her authorized representative. Prior quarter coverage is not automatically extended to all new enrollees; it must be requested. To enroll, the applicant must check the box in the Medicaid application that indicates they have medical expenses in the three months prior to application and that they want to have assistance paying them. However, for the initial implementation of the Medicaid expansion, FSD will automatically assess eligibility for prior quarter coverage back to July 1 for expansion eligible adults applying before October 1, 2021.

ii. Even if a MO Healthnet participant did not request prior quarter coverage at the time of application, he or she may request it within 12 months of beginning coverage, or a hospital can work with a patient to help them apply for prior quarter coverage within the first year of coverage.

iii. An applicant for prior quarter coverage must provide income data to demonstrate that they met the standards for Medicaid coverage in each of the three months prior quarter coverage is requested.

12. How would prior quarter coverage interact with the effective date of Medicaid expansion?

Prior quarter coverage for the expansion population cannot be provided to periods before the July 1, 2021, implementation date set by the constitutional amendment.

13. What is presumptive eligibility?

Medicaid presumptive eligibility allows for certain low-income pregnant women, children and their parents who are in the process of applying for Medicaid to qualify for temporary Medicaid coverage immediately while their application for ongoing coverage is pending. Medicaid will pay the cost of allowable health care services for individuals covered under the presumptive eligibility process even if their regular application for Medicaid coverage is not approved. Hospitals wishing to do so may perform presumptive

eligibility determinations for the expansion-eligible adult patients with FSD's prior approval.

Hospitals wishing to perform presumptive eligibility determinations for expansion adults must sign an MOU with and receive training from DSS FSD. Interested hospitals should complete this checklist and submit it along with a request to become a presumptive eligibility qualifying entity to DSS FSD at COLE.MHNPolicy@dss.mo.gov. More information on presumptive eligibility is available on the state's website at the Presumptive Eligibility (PE) Resources for Providers webpage.

Participating hospitals and clinics are required to help the presumptive eligibility enrollee apply for ongoing Medicaid coverage. The presumptive eligibility period ends when the application for regular coverage is processed. If an application for regular coverage is not submitted, the presumptive eligibility coverage ends on the last day of the month following the month the presumptive eligibility determination was made. Presumptive eligibility only can be approved for an individual one time in a 12-month period.

IMPORTANT: Hospitals that currently have an agreement with DSS FSD to perform presumptive eligibility determinations are not permitted to perform determinations on expansion adults. Hospitals MUST sign an amended MOU before performing determinations for expansion adults. FSD expects to begin distributing amended contracts to and scheduling training for hospitals interested in performing Medicaid expansion presumptive eligibility determinations the week of September 27, 2021.

14. Who are authorized representatives?

An individual is allowed to designate one or more authorized representatives to help them apply for MO HealthNet benefits. An authorized representative will act on an individual's behalf to help them complete the application process. Authorized representatives may file an application for Medicaid coverage and submit the requisite documentation on an individual's behalf, receive communications from DSS about the individual's case and application status, have access to the individual's online DSS account and receive communications from DSS, including communications with the individual's personal health information.

Individuals may not designate an organization to be their authorized representative. An authorized representative must be a person.

An authorized representative's delegation ends once the individual's application has been approved or rejected. An individual may rescind their authorized representative's designation at any time.

One does not need to be named an authorized representative to help another complete an application, although DSS will not communicate with or accept documentation from the person providing assistance unless he or she is designated as an authorized representative.

15. Will expansion adults be enrolled in managed care?

Yes. All Medicaid expansion adults will have their benefits administered by one of the three existing MO HealthNet managed care plans (Home State, United Community Health Plan or Healthy Blue).

16. How will Medicaid expansion participants be enrolled in managed care?
MO HealthNet managed care enrollment for individuals eligible under the Medicaid expansion will be the same as the current process for MO HealthNet eligible parents, children, and pregnant women. Newly eligible MO HealthNet participants are automatically enrolled with one of the three plans, and the plan in which the participant is enrolled will be responsible for paying for the participant's care beginning the first day the participant is eligible for coverage.

Newly eligible participants are not allowed to select a managed care plan during the MO HealthNet application process. All initial assignments are made automatically by MO HealthNet's Managed Care enrollment broker after the applicant is determined to be eligible for coverage.

Newly enrolled patients have 90 days from the date they are enrolled in a managed care plan to change plans. Changes in this first 90 day period can be made without cause online or by completing and submitting this form. Participants may also call the managed care enrollment broker at 800-348-6627 to change their plan or to get information about plan provider networks. After the 90-day period, changes may be made with cause.

Additional information can be found in MO HealthNet's Managed Care Guide.

17. What state agencies have responsibility for implementing Medicaid expansion?
The roles of the agencies of government with responsibilities for administering the Medicaid expansion (and the Medicaid program generally) are described below.

MO HealthNet Division: MO HealthNet is the state agency that administers the Medicaid benefit. MO HealthNet is responsible for establishing Medicaid policy in accordance with the state's approved Medicaid state plan. MO HealthNet contracts with three managed care plans — Centene (Home State), United (United Community Health Plan), Anthem (Healthy Blue) — to deliver care for parents, kids, and pregnant women currently, and the Medicaid expansion adults in the future. MO HealthNet's responsibilities include setting the scope, duration and limits of covered benefits, rates paid to providers for covered services, managed care contracting and enrollment, etc. MO HealthNet pays providers for elders and disabled participants who are covered on a fee-for-service basis (as opposed to managed care.)

Family Support Division (FSD): Historically, known as the Division of Family Services, or DFS, FSD determines eligibility for Medicaid coverage. FSD takes applications, verifies compliance with the eligibility standards, and renders decisions on applicants' eligibility. FSD's responsibilities include determining initial and continued eligibility for coverage (including eligibility for prior quarter coverage, taking applications on-line,

over the phone and in paper form mailed in or dropped off at a local office. FSD has offices in every county of the state, and multiple offices in the metropolitan areas.

Missouri Medicaid Audit and Compliance (MMAC): MMAC is responsible for provider enrollment and post-payment reviews and compliance audits. Health care providers currently enrolled in Missouri's Medicaid program are qualified to provide services to newly covered Medicaid expansion participants without further action. Rules for provider participation are the same for the Medicaid expansion as for the existing Medicaid program.

Department of Social Services (DSS): DSS is the umbrella agency that that encompasses the MO HealthNet Division, FSD and MMAC.