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I=A, EXHIBIT 26
FOCUS GROUPS FINDINGS

St. Louis

Medicaid Consumers

1. Racially mixed but mostly African American; SES same as working poor (underclass)
2. Define health care in terms of access to services/providers
3. Emphasis on restricted/limited access to services

Working Poor

1. Racially mixed but mostly white;SES same as Medicaid consumers (underclass)
2. Define health care in terms of access to insurance/treatment
3. Emphasis on availability of services

Jefferson County

1. White; SES same as working poor (underclass)
2. Define health care in terms of access to services/providers
3. Emphasis on limited access to services

1. White; SES same as Medicaid consumers (underclass)
2. Define health care in terms of access to insurance/treatment
3. Emphasis on availability of services

- All group participants came from the same SES level (less than $15,000 per year i ncome.)
- Medicaid consumers defined their health care concerns in terms of the current Medicaid system focusing most often on problems of access to providers.
- The working poor share many of the same health care concerns but focus more on insurance as the key to a market place of health care services presently unavailable to them.

I - B. CONSUMER PROTECTIONS

Consumer protections for waiver participants members will consist of:

- An informal and a formal grievance process.
- Rights of patients to transfer between plans and among doctors within plans.
- Plan- and provider-initiated transfer and disenrollment processes.
- State monitoring of all transfers and disenrollments.
- A consumer guidebook.

Members will have the right to file formal complaints and grievances with both managed care plans and the state. These grievances may be filed simultaneously, however, the state will encourage plans and members to resolve complaints before the state would take action. In addition, following the 30-day initial enrollment period — during which members can change plans for any reason — members will be allowed to transfer between plans if they establish good cause. Because transfer requests may indicate poor service, they will be monitored by the state. Members will be able to change physicians within plans. In addition, a consumer guidebook will be published after year two of the Demonstration Project.

A. GRIEVANCE PROCEDURES

Members can file grievances on any aspect of service provided to them by plans or the members' chosen doctors. The grievance system will consist of:

- A consumer relations office which members can use to ask questions and get problems resolved without going through the formal, written grievance process. This aspect of the grievance system will be "informal" and operate through verbal communication.

- A formal grievance process which members can use to file official complaints. This process will require a written, substantiated complaint from members.

Both members and plans should first attempt to resolve complaints through the informal process before initiating a formal complaint.

The State will maintain its existing grievance process and membership services in its Recipient Services unit, but expand its duties to handle waiver participants. Within this unit, the state will house an Ombudsman. In addition, a Consumer Advisory Committee will assist in the development of educational materials and descriptions of consumer rights. This Committee will be representative of Missouri's Waiver population in terms of race, ethnicity and medical conditions such as pregnancy and physical disabilities.

Plans, as part of their grievance systems, shall:

1. Develop written policies and procedures which detail the operations of the two components of the grievance and how to file a complaint. These policies and procedures shall be approved by the state prior to implementation.

2. Operate a consumer relations office adequately staffed to receive phone calls and meet personally with waiver participants.

3. Identify a person in the plan who is specifically designated to receive and process formal grievances.

4. Mail an information packet on the grievance system to members within 14 days following enrollment. This packet should include the grievance system's policies and procedures, as well as specific instructions regarding how to contact the consumer relations office. It should identify the person who handles formal grievances and provide simplified instructions on how to file a formal complaint.

5. Respond to written complaints in writing within 14 days after receiving a grievance, except in cases of emergency when the response must be made as soon as possible.

6. Operate a grievance appeals process through which members can appeal any negative response to their grievances directly to the Boards of Directors of the plans. The Boards of Directors may delegate this authority to a grievance appeal committee, but the delegation must be in writing.

7. Maintain records of informal grievances that include a short, dated summary of each of the questions and/or problems, the response, and the resolution. If the plan does not have a separate log for waiver participants, the log shall distinguish waiver participants members from other plan enrollees.

8. Maintain formal grievance records that include a copy of the original grievance, the response, and the resolution. This system shall distinguish waiver members from other plan members.

9. At the time of the plan's initial decision regarding complaints and grievances, the plan shall notify members of their right to appeal to both the plan and the state.

10. Assure plan executives with the authority to require corrective action are involved in the grievance process.

B. TRANSFERS & DISENROLLMENT

Member-initiated transfers and disenrollment

All transfers among plans that members request during the first 30 days following initial enrollment will be granted without review by the state. The same applies to the annual, 30-day open enrollment period. However, those that are initiated at other times may indicate dissatisfaction with services, poor service, or misunderstandings. Because of the potential for abuse and misunderstanding, the Division of Medical Services' Quality Assurance Unit will monitor these requests. Possible reasons for a member to request a transfer include, but are not limited to dissatisfaction with:

- Accessibility — transportation, physician office hours, phone accessibility, waiting times.
- Acceptability — comfort, surroundings, staff attitudes.
- Quality — diagnosis, treatment, referrals.
- Enrollment — wrong provider on card, disliked provider if a random assignment by state, provider no longer participating, member changes address.

Transfer requests will be monitored and approved by the state. In monitoring transfer requests that occur at times other than open enrollment and the 30 days following initial enrollment, the Quality of Assurance Unit shall:

1. Review all transfer requests.

2. If warranted, investigate those transfer requests that indicate a quality of care concern. The investigation may consist of phone interviews, letters, or interviews with recipients and providers.

3. Resolve those transfer requests that may require education for the provider or member to settle the request without carrying it through.

4. Compile and analyze data on transfer requests to look for significant patterns that may indicate unwillingness to serve high-risk recipients as well as recipient abuse of the transfer procedure.

Open enrollment will occur near the end of each calendar year. If no transfer is requested, enrollment with the current plan will continue. Members may disenroll from the waiver program at any time by notifying the State. The state will review these notifications to assure that the decisions were freely made by the recipients.

Plans must also develop transfer policies that allow waiver members to change physicians within plans. At least two such changes a year shall be allowed, and members will be informed of the process for initiating these changes.

Health-plan initiated disenrollment and transfers

Disenrollment may follow a member's moving out of the geographic area covered by a plan or because a member becomes ineligible. In addition, plans may initiate disenrollment and providers may request patient transfers to other providers or other plans if plans can substantiate:

1. A persistent refusal of the patient to follow prescribed treatments or comply with health plan requirements that are consistent with state and federal laws and regulations.

2. Consistently missed appointments without prior notification to the provider.

3. Misuse of the system or abusive conduct.

Plans that recommend disenrollment or transfers for reasons other than these may be subject to financial sanction.

In particular, plans may not initiate disenrollment because of a medical diagnosis unless the diagnosis results in a Medicaid-eligible, member being qualified for services unaffected by the waiver.

Plans must first give prior notification at least three times to the member before beginning disenrollment or transfers. Within 10 working days of the final notification, members will be re-enrolled in another health plan, transferred to another provider, or disenrolled from the waiver program. These disenrollment requests must be approved by the Quality Assurance unit and will be subject to the same review procedures listed above for transfer requests initiated by members.

Members will have the right to appeal a plan-initiated disenrollment to both the state and health plan grievance systems. This appeal must be initiated prior to the third notification of the member by the plan. When members file an appeal, the appeals process must be complete prior to the plan and state continuing disenrollment procedures.

C. CONSUMER GUIDEBOOK

After year two of the Demonstration Project, consumer guidebooks will be published and made available to all members. At a minimum, the consumer guidebook will include:

- Summaries of transfers — among plans and between provider —and disenrollments, their reasons and findings of all investigations.
- Reports of consumer surveys (described in Chapters 2 and 4).
- Findings of outcome evaluations and compliance rates with quality assurance standards.

I - C. RECOMMENDATIONS OF THE MEDICAID CONSUMER ADVISORY GROUP

1. Establish sound doctor-patient relationships: Doctors and their patients should know each other and have the opportunity to develop stable and ongoing patient-caregiver relationships. These relationships should lead to consistent information and advice given by physicians to their patients. Health plans should include doctors' preferred hospitals in their provider networks. (What shouldn't happen: Every time a patient shows up at a doctor's office a different doctor sees him or her.)

2. Streamline access to specialty services: Access to specialized services needs to be simplified and these services need to be coordinated by patients' personal physicians. Referral policies should be consistent among plans and among providers within plans. If a doctor refuses a referral, members should have the right to a second opinion, including an opinion from a physician within a different plan. Procedures should be established to reconcile conflicting diagnoses. (When a patient needs a specialty service, he or she shouldn't have to hunt through the phone book and shop the clinics, hospitals and doctors' offices in search of a provider..)

3. Increase access to preventive care: Preventive, front-end care should be easily accessed. (Sporadic, "Band-Aid" care for emergency and urgent needs shouldn't be the routine care patients receive.)

4. Encourage self-sufficiency: Members should be able to work, receive an income, and provide for their children without the threat of having access to health care cut off. Health benefits should be gradually phased out, based on income not time, as a member transitions from public assistance to self sufficiency. Calculation of income should exclude day care expenses and an allowance for food and shelter. (Members shouldn't lose all health coverage for being slightly out of eligibility guidelines. Members who do not receive public assistance for day care, housing or food should not have this counted against them in determining their eligibility.)

5. Require patient responsibility: Penalties — such as fees or reassignment to a different doctor within a plan — should be applied to those patients who consistently misuse services through actions such as repeatedly missing appointments or routinely using emergency rooms for non-emergency situations. Safeguards should ensure that sufficient prior notifications are given before penalties apply, and this policy should be thoroughly explained to members during enrollment. (Conscientious, responsible members should not be lumped together and perceived negatively because of the irresponsible behaviors of a few members.)

6. Protect Consumers: A thorough consumer protection system should be established that includes:

- The ability to change plans or doctors within a limited time period immediately following enrollment.
- Access to information on physicians and health plans 30 days prior to enrollment deadline.
- The right to file complaints and grievances against plans and doctors.
- Prohibition against plans or doctors refusing to see a member due to pre-existing conditions.
- Familiarity among privately contracted enrollment counselors with other public programs.
- The right to second opinions (see recommendation No. 2).

(Members should not be solely reliant on providers for information, nor should they be blocked from addressing and resolving situations in which they feel they were treated unfairly or did not receive covered services.)

7. Treat members with courtesy: Members should be treated with the same respect as patients with private health insurance. (Members shouldn't have to be rudely turned away by providers as they search for a doctor willing to see them. And once in an office, waiting times and other courtesies should be the same as other patients.)

8. Provide comparable quality: The quality and choice of needed medical equipment — such as eyeglasses, wheelchairs, and other durable medical goods — available to members should be similar to that available to patients with private insurance. If willing, members should be allowed to pay the difference for equipment not included in plan choices.

(Members should not be prohibited, even if willing to pay extra, from choosing from the same goods and equipment that private-pay patients have access to.)

2-A. CARE FOR BEHAVIORAL HEALTH

The basic benefit package for the Waiver largely addresses the physical health care needs of Missourians. Although the basic benefits do include access to limited, basic behavioral health services which will serve many Missourians experiencing a temporary mental health or substance abuse crisis, the basic benefit package is not intended to serve as the comprehensive behavioral health system. The needs of Missourians experiencing sustained mental health or substance abuse problems, or those in acute crisis, many of whom will experience ongoing interruption of their ability to function in society, must be addressed as well. Therefore, Missouri will also offer coverage of targeted, comprehensive behavioral health benefits for Missourians up to 200% of poverty who are severely and persistently mentally ill, seriously emotionally disturbed children and those who have sustained need for residential and intensive outpatient substance abuse services. These targeted behavioral health care benefits will be provided through the Department of Mental Health and its network of state and private providers, which will be phased to a capitation payment system for all Waiver Behavioral Health participants.

THE CURRENT BEHAVIORAL HEALTH MEDICAID SYSTEM IS FRAGMENTED AND INEFFICIENT

Missouri currently delivers behavioral health care services through a network of state and private entities. Both the mental health and the substance abuse systems have developed service areas which are identified with providers who have the on-going responsibility of insuring that services are available to target clients within the service system area. These entities have become Medicaid enrolled providers, reimbursed under the Medicaid fee-for-service system, with substantial portions of their population identified as Medicaid eligible. As the mental health and substance abuse delivery system responds to the needs of their Medicaid eligible populations, they have had to operate within the Medicaid program's limitations and requirements. This has led to service system fragmentation and a limited ability to provide incentives to use the most appropriate and cost-effective services.

BEHAVIORAL HEALTH UNDER THE WAIVER WILL ALLOW THE MENTAL HEALTH SYSTEM TO PROVIDE INCENTIVES TO USE THE MOST APPROPRIATE AND COST EFFECTIVE SERVICES

Under the Waiver, Missouri will continue its coverage of behavioral health but in a more accessible, accountable and comprehensive behavioral health system. Missouri proposes to cover those behavioral health services necessary to meet the needs of the target population within the management and service delivery structure of the Missouri Department of Mental Health, with the phase-in of managed care and capitation, and the elimination of fee-for-service as the normal payment methodology. Missouri will draw on the expertise and experience in the existing provider system as it moves from the current one-service-area, one-provider system to service regions which are compatible with the new delivery system. This will offer greater client choice and access by providing a variety of experienced behavioral health providers for clients. In addition, there will be dedicated and coordinated entry and exit points into and from the targeted comprehensive behavioral health system. As a result of these changes, members in the target behavioral health population will have increased access; there will be coordination of behavioral health benefits and there will be measurable accountability for outcomes. Coordination between the physical and behavioral health systems will be part of the quality assurance requirements for both programs.

Participants in the Behavioral Health program will receive the standard benefit package from the plan of their choice. The standard benefit package includes behavioral health services that will meet the needs of about 97 percent of members.

Access to Behavioral Health Waiver services will be through the Department of Mental Health's network of state and private providers, including the use of lower cost psychiatric facilities by the capitated providers where such usage in the past would have been prohibited for a Medicaid recipient due to the requirements around receipt of federal financial participation while the recipient was in an institution for mental diseases. Incentives to encourage the use of the most appropriate care will be built into the quality assurance system in addition to the natural incentives built into the use of capitation.

Primary and secondary consumers will be on-going participants in the quality assurance process, as well as in policy review and recommendation. Consumer advisory committees will be established to participate as advocates in both of those systems.

While the health plans will be responsible for the physical health benefits, the Missouri Department of Mental Health and its operating divisions and contractors will be responsible for mental health interventions beyond the basic benefit package, excluding some mental health intervention for children and families receiving protective services for children in custody through the Missouri Division of Family Services.

MISSOURI PROPOSES A PILOT TO ADDRESS A NATIONAL BEHAVIORAL HEALTH ISSUE

In the current market, physical health providers frequently see dedicated behavioral health services as difficult to access, unable to attract the best practitioners and a place where only the most severely involved persons are treated. Dedicated behavioral health systems tend to see the behavioral health services that are adjunct to the physical health system as skimming off valuable time and resources to a mental health system that is not capable to follow through and that largely focuses on unneeded hospitalization or therapy visits. The recipient of behavioral health services often falls through the crack in the two systems.

In order to respond to the need to integrate all behavioral health services, Missouri proposes to pilot a delivery system in one area of the state that will fully integrate all behavioral health services for Missouri Medicaid recipients.The provider system in which comprehensive behavioral health services are offered will be developed by competitive proposal from any interested provider. By integrating the behavioral health component of the standard benefit package with the targeted behavioral health services, Missouri will learn if the behavioral health needs of Waiver members can best be served by providers responsible for the entire range of behavioral health services needed by all Missourians.

The Missouri pilot will carve out a distinct geographic area in which providers are chosen for their ability to provide the entire range of comprehensive behavioral health services which meet the spectrum of mental health and substance abuse needs. Capitation will be used to promote more efficient management of all of the needs of these special populations, at the same time allowing providers to exercise their best clinical and management judgment about appropriate services.

2-B. PILOT PROJECT FOR THE PERMANENTLY AND TOTALLY DISABLED

This program will develop a capitated managed care system for individuals with physical disabilities. Invariably, physical disability results in multiple medical problems. Often, the disabled condition influences the entire medical presentation as well as the utilization of medical services.

Primary care providers are often poorly prepared to address disabling conditions and the medical sequelae. It is well documented that a small minority of individuals account for a disproportionate amount of health care spending. One percent of the US population is responsible for 30 percent of health expenditures; 10 percent of the US population accounts for 72 percent of health care spending. Yet current models of cost containment emphasize savings through capitation of relatively healthy individuals in organized systems of care, most typically, staff model health maintenance organizations. This approach attempts to manage health care costs by managing the healthy and ignoring those with systematic and costly medical needs.

This recognition — that individuals with disability are high utilizers of costly medical care — calls for the development of specific systems of care that address the disability. Hopefully, these systems will prove highly effective in controlling health costs as well as providing high quality of care. A key component of our proposal is the use of physiatrists, rather than primary care physicians, as the medical gatekeeper. The use of individuals trained in primary care models may result in under-treatment of the disabling condition. An alternative model is to use health care practitioners trained in rehabilitation to address both the primary and secondary care problems of individuals who have disabling conditions.

Physicians with specialty training in the care of individuals with disabilities — physiatrists — receive one year of training in fundamental skills and four years specialty training. Physiatrists are prepared to treat chronic disabling conditions affecting aging individuals as well. In addition, physiatrists routinely work with an interdisciplinary team including physical therapists, occupational therapists, nurses, psychologists, and social workers. These treatment teams function in a manner similar to primary care gate-keeper referral models currently viewed as capable of containing escalating health costs.

Use of physiatrists as primary care providers for individuals with disability has been frequently discussed in the rehabilitation community. Unfortunately, this is a relatively small aspect of health care. Consequently, only limited national attention has been directed to this concept. Empirical evaluation of this model is warranted, especially if demonstration of the model could occur in areas lacking effective primary care providers.

Missouri lacks adequate numbers of primary care providers in almost half the counties in the state, especially rural areas. Individuals with disability living in rural areas face even more difficulties. Routine accessibility can often be limited. Available health providers are often burdened and have limited time and knowledge of the complex medical conditions these individuals often experience. Referral to tertiary care centers routinely results, creating a myriad of problems including time away from family, transportation difficulties, and escalating medical costs.

This proposal calls for collaboration between the Division of Medical Services and the University of Missouri Medical School and Hospital, and Rusk Rehabilitation Center. The target population includes all physically disabled individuals eligible for Medicaid due to their disability, residing in the middle section of Missouri. Included in this area are the counties of Audrain, Boone, Callaway, Cole, Cooper, Howard, Maries, Miller, Morgan, and Randolph. There are approximately 2000 individuals in these counties who will meet this criteria.

The project will utilize existing clinics located in the communities and operated by the University program to establish a "hub and spoke program" for these individuals with disability. Each individual will be asked to choose a gatekeeper clinic and corresponding physiatrist to provide and coordinate all medical services. Tertiary care referrals will be made only when necessary and appropriate. Participation will be voluntary with lock-in requirements. However, full cooperation from clients is anticipated.

Rusk Rehabilitation Center and many of its programs rely heavily upon consumer evaluation and input. This program will be reviewed by a panel of consumers. The panel will meet every six months to evaluate program outcome measures, consumer satisfaction, and efficiency.

The Missouri Division of Medical Services will collaborate with the University of Missouri to design specific program elements, capitalizing on their expertise with the disabled and their resources as the major health care provider in the target area. In turn, Medicaid staff will contribute knowledge of how to structure fair and reasonable capitation rates in accordance with federal Medical law and regulation. Staff from two Medicaid units will be assigned as needed to this project. Policy staff will coordinate this program with other programs dealing with the disabled. There is particular interest in the relationship between this endeavor and the many other programs Missouri operates for the disabled, particularly the head injured. We have numerous programs for the head injured individual, however, there is only minimal Medicaid involvement with those programs. Managed care staff will provide expertise in rate setting, stop loss provisions, scope of contractual services, etc. In doing so, our ten years of experience in Medicaid managed care in Kansas City will be called upon.

This proposal offers a unique opportunity to learn more about several issues pertinent to the management of individuals with disability. The influence of a rural rate for individual with disability and their health providers will be evaluated. In addition, the use of alternative providers, including physiatrists and mid-level practitioners, will be explored. The findings from the proposal could be of material significance for Medicaid programs, individuals with disability, and health professional alike.

2-C. MEDICAID ELIGIBILITY CATEGORIES

1. Aid to Families with Dependent Children (AFDC)

- Approximately 265,000 (46%) of the Missouri Medicaid population consists of families who receive Aid to Families with Dependent Children (AFDC). The Missouri payment standard which determines AFDC eligibility is 28 percent of the federal poverty level (FPL).

2. Children and Pregnant Women

- Over 100,000 (17.4%) of current recipients are children in families that do not receive AFDC, but who are eligible for Medicaid depending on age and family income, including:
  - infants under age one in families with incomes not exceeding 185% of FPL;
  - children ages one through five in families with income not exceeding 133 percent of the FPL;
  - and children age six through 18 in families with income not exceeding 100 percent of the FPL.
- Another 15,000 (2.6%) are families who have lost AFDC benefits because of income or employment and are eligible for transitional Medicaid if their income level does not exceed 185% of the FPL.
- An additional 7,000 newborns (1.2%) are eligible for one year because they were born to women receiving Medicaid at the time of birth.
- Close to 12,000 (2.1%) Medicaid recipients are pregnant or post-partum women with incomes not exceeding 185% of the FPL.

In addition to the income requirements listed above, families with minor children eligible for Medicaid by virtue of their AFDC eligibility are limited to assets of $1,000, excluding a home.

3. Aged, Blind, or Disabled

- Approximately 135,000 Medicaid recipients (23%) are aged, blind, or disabled individuals who receive Supplemental Security Income (SSI), or mandatory state supplements, or whose incomes are at 85% of the FPL.

(Missouri is a so-called § 209(b) State and therefore does not make Medicaid available to all SSI recipients. However, SSI recipients and other aged, blind, or disabled individuals whose income is above 85% of the FPL may still qualify for Medicaid if they meet state spenddown requirements.)

- 7,500 Medicaid-eligibles (1.2%) are Qualified Medicare Beneficiaries only (QMBs) whose income does not exceed 100% of the FPL and for whom Medicaid will pay Medicare premiums, deductibles and coinsurance, or Specified Low-Income Medicare Beneficiaries only (SLMBs) whose income does not exceed 110% of the FPL and for whom Medicaid will pay the Medicare Part B Premium;

- 3,000 recipients of Medicaid recipients (.5%) are elderly individuals whose incomes are below 132% of the FPL and who receive health care services through the Medicaid home- and community-based waiver program;

- Over 7,000 individuals (1.2%), whose income levels vary with their living arrangements, receive supplemental nursing care payments and Missouri Medicaid.

Missouri also has several state-only (non-federally matched) categories of medical assistance. The State's Blind Pension program assists over 2,000 blind persons who do not qualify for Federal Aid to the Blind and who are not eligible for SSI. The State's General Relief (GR) program offers limited health care services to approximately 6,500 needy and unemployable adults whose incomes are below 31% of the FPL and who cannot qualify under any other type of assistance.

2-D. WAIVER ELIGIBILITY

Determination of 200 % of Federal Poverty Level

In comparing household income to 200% of the FPL, the following guidelines will be followed at the time of application :

- The previous 60 days of income will be used to calculate yearly income;
- Current income will be documented by way of an award letter, recent wage stub, employment contract, or other normally acceptable document;
- For seasonal, contract, and occasional work, estimated annual income will be used;
- If it is anticipated that no income will be received for future months due to illness, accident, or other reasons, and this can be verified, no income will be considered available.

Exclusions from income

The following types of income will not be included in income determinations:

- earnings of a child;
- income from participating in volunteer programs;
- interest or dividends (unless assets exceed $100,000, excluding a homestead);
- loans;
- scholarship and student loans; and
- other income clearly earmarked for a specified purpose.

Deductions from income

The only allowable deductions from income will be legally obligated child support and payments made to someone outside of the household for expenses of producing self-employment income.

Defining a Household

For purposes of the Waiver program income review, a household will be defined as:

- a parent and his/her biological or adoptive children living in the home;
- a married couple living together, including their children and including a step-parent, whether they have any biological or adoptive children in the home or not;

- a single child (and his/her siblings if living together) in the legal or physical custody of the State, but not including foster children;

- a single person (including a child) living alone or with others who would not be defined as specified relatives;

and where:

- child means child under age 18 who is not married; and

- specified relatives means spouses, brothers and sisters under age 18, and parents and their biological or adoptive children under age 18.

Specified relatives must be included in the household if living together.

1. Basic Household Information

Applicants under the waiver must provide the following basic household information:

- social security number;

- birth date of all household members;

- statement of relationship of household members.

Individuals must declare whether they are U.S. citizens and their legal status if they are non-citizens. Legal aliens who are Missouri residents will be covered by the Waiver. Illegal aliens will not be eligible for the Waiver program but may still receive emergency room services under Medicaid on a fee-for-service basis.

3-A. POLICY OF NON-DISCRIMINATION

A significant portion of the population served by the Waiver Program will be minorities, including African-Americans, Asians, Hispanics and others. It is the Department's expectation that the contractor's goals, objectives and mission be consistent with the needs of the population being served.

Minority representation should be a key component of the executive decision-making level of the contractor's organization. By way of example, this can be demonstrated by having minority representation on its board of directors or as senior personnel of the contractor's organization.

Minority health care providers and community based organizations should be integrally involved in the service delivery system. The Department expects that minority physicians and other health care providers will be an integral part of the service system in each zone.

It is the policy of the State of Missouri to maximize opportunities for minority business enterprises to participate in the performance of contracts awarded by any state department or agency. In this regard, minorities must have equal opportunity so that ethnic and cultural diversity are reflected in the Waiver Program. Successful contractors are obligated to ensure that the Department of Social Services policy of non-discrimination is strictly enforced.

The Department expects contractors to have a commitment to enhance the economic health of the community being served by the Waiver program. Examples of this commitment include:

1. Having an office located in the area being served by the contractor.

2. Recruiting and hiring qualified individuals who live in the area being served by the contractor.

3. Involving community based organizations located in the area being served as part of the health care system.

Although not a requirement, the Department encourages special initiatives that may be developed by the contractor to encourage and support Medicaid recipients in the area to pursue careers in the health care field. This is an example of returning value back to a community and is consistent with other efforts by the Department to break the cycle of dependency of welfare recipients.

In summary, the Department is emphasizing its total commitment to assuring minority participation at all levels of the Waiver Program. Although there will be many references to this commitment throughout the RFP this clarification repetition should serve to reemphasize that commitment. The contractor's commitment to the policy of minority inclusion and non-discrimination must be described and documented in the bidder's proposal for the purpose of evaluation and scoring.

The Department will require selected contractors to comply fully with its policy of non-discrimination and the stated goals and objectives detailed in this proposal both during the developmental phase and through the life of the contract.

NONDISCRIMINATION POLICY

The Missouri Department of Social Services (DSS) hereby reaffirms its commitment to the principles of fair employment practices and equal access to services.

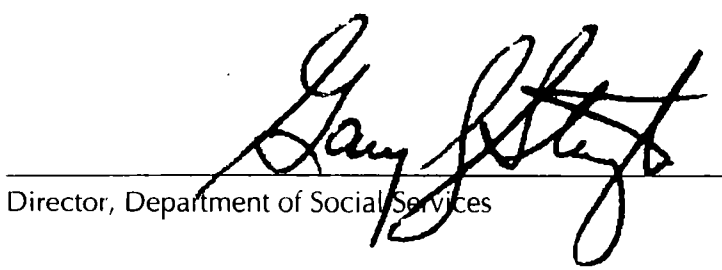
DSS shall take affirmative action to ensure that applicants, employees, clients and contractors are treated equitably regardless of race, color, national origin, sex, age, religion, political beliefs, ancestry, veteran, or handicap status. With respect to age, sex, handicapping conditions, restrictions will be related to a bona-fide occupational qualification (BFOQ), or business necessity unless otherwise established by state or federal statute.

DSS contracts and vendor agreements shall contain similar equal opportunity and nondiscrimination clauses and assurances, as mandated by the Governor's Executive Order, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, The Americans With Disabilities Act of 1991 and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS, who believe they have been denied a service or benefit because of race, color, national origin, sex, handicap, age, political belief or religion, may file a complaint by calling 1-800-776-8014, TDD: 1-800-877-6916. Complaints may also be filed by contacting the local service office or by writing to the Office for Civil Rights, P. O. Box 1527, Jefferson City, MO 65102.

Persons who believe they have been discriminated against in any United States Department of Agriculture related activity (Food Stamps, Commodity Food, etc.) may also write to the Secretary of Agriculture, Washington, D.C. 20250.

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees and applicants for employment, in all Divisions, institutions and offices governed by DSS. This policy shall be stated in all employee orientation programs, printed in the DSS Administrative Manual and other appropriate material.



Director, Department of Social Services

3-B. MISSOURI POPULATION DISTRIBUTION BY COUNTIES WITH HMO LICENSEES

1994 General County/City	Percent Population	Adjusted Waiver Total	Percent Population	Number HMO Total	Licensees
Andrew	15,044	0.3%	663	0.2%	1
Atchison	7,667	0.1%	385	0.1%	1
Buchanen	85,421	1.6%	8,141	2.0%	3+
Caldwell	8,616	0.2%	665	0.2%	1
Carroll	11,050	0.2%	899	0.2%	1
Cass	65,604	1.2%	3,115	0.8%	3+
Clay	157,728	3.0%	5,065	1.3%	3+
Clinton	17,062	0.3%	890	0.2%	2
Daviess	8,086	0.2%	536	0.1%	1
Dekalb	10,247	0.2%	497	0.1%	1
Gentry	7,041	0.1%	291	0.1%	1
Harrison	8,707	0.2%	581	0.1%	1
Holt	6,204	0.1%	278	0.1%	1
Jackson	651,052	12.4%	60,957	15.3%	3+
Johnson	43,710	0.8%	2,321	0.6%	1
Lafayette	31,982	0.6%	1,993	0.5%	3+
Nodaway	22,320	0.4%	793	0.2%	1
Platte	56,411	1.1%	1,634	0.4%	3+
Ray	22,589	0.4%	1,092	0.3%	3+
Worth	2,509	0.0%	226	0.1%	1
Total Northwest	**1,239,051**	**23.6%**	**91,022**	**22.8%**	
Adair	25,269	0.5%	1,120	0.3%	1
Chariton	9,461	0.2%	469	0.1%	0
Clark	7,759	0.1%	554	0.1%	0
Grundy	10,832	0.2%	744	0.2%	1
Knox	4,608	0.1%	237	0.1%	1
Lewis	10,521	0.2%	643	0.2%	1
Linn	14,276	0.3%	953	0.2%	0
Livingston	15,003	0.3%	1,053	0.3%	1
Macon	15,777	0.3%	873	0.2%	1
Marion	28,461	0.5%	2,528	0.6%	0
Mercer	3,828	0.1%	208	0.1%	1

Monroe	9,360	0.2%	444	0.1%	0
Pike	16,418	0.3%	1,096	0.3%	3+
Putman	5,222	0.1%	401	0.1%	0
Ralls	8,715	0.2%	512	0.1%	0
Randolph	25,056	0.5%	2,302	0.6%	1
Saline	24,185	0.5%	1,849	0.5%	1
Schuyler	4,355	0.1%	265	0.1%	0
Scotland	4,958	0.1%	325	0.1%	3+
Shelby	7,137	0.1%	487	0.1%	1
Sullivan	6,504	0.1%	423	0.1%	1
Total Northeast	**257,705**	**4.9%**	**17,486**	**4.4%**	
Audrain	24,263	0.5%	1,626	0.4%	0
Boone	115,541	2.2%	6,651	1.7%	3+
Callaway	33,732	0.6%	2,128	0.5%	3+
Camden	28,269	0.5%	1,589	0.4%	2
Cole	65,368	1.2%	2,772	0.7%	3+
Cooper	15,252	0.3%	839	0.2%	2
Crawford	19,713	0.4%	1,945	0.5%	3+
Dent	14,088	0.3%	1,462	0.4%	0
Gasconade	14,400	0.3%	657	0.2%	3+
Howard	9,902	0.2%	541	0.1%	2
Laclede	27,922	0.5%	2,210	0.6%	0
Lincoln	29,705	0.6%	1,803	0.5%	3+
Maries	8,200	0.2%	552	0.1%	2
Miller	21,283	0.4%	1,966	0.5%	3+
Moniteau	12,644	0.2%	548	0.1%	2
Montgomery	11,675	0.2%	833	0.2%	3+
Morgan	16,012	0.3%	1,370	0.3%	2
Osage	12,356	0.2%	309	0.1%	3+
Pettis	36,434	0.7%	2,979	0.7%	1
Phelps	36,240	0.7%	2,797	0.7%	3+
Pulaski	42,469	0.8%	2,437	0.6%	1
St Francois	50,280	1.0%	5,049	1.3%	3+
Ste Genevieve	16,488	0.3%	860	0.2%	3+
Warren	20,084	0.4%	1,313	0.3%	3+
Washington	20,954	0.4%	3,765	0.9%	3+
Total Central	**703,275**	**13.4%**	**49,002**	**12.3%**	
Franklin	82,871	1.6%	4,704	1.2%	3+
Jefferson	176,203	3.4%	9,185	2.3%	3+
St Charles	218,909	4.2%	6,710	1.7%	3+
St Louis	407,848	7.8%	44,522	11.1%	3+

St Ls City	1,021,488	19.4%	74,213	18.6%	3+
Total St. Louis	**1,907,319**	**36.3%**	**139,335**	**34.9%**	
Barry	28,322	0.5%	2,282	0.6%	0
Barton	11,630	0.2%	815	0.2%	0
Bates	15,448	0.3%	1,264	0.3%	1
Benton	14,249	0.3%	1,126	0.3%	1
Cedar	12,433	0.2%	1,118	0.3%	1
Christian	33,563	0.6%	2,014	0.5%	0
Dade	7,659	0.1%	581	0.1%	1
Dallas	13,002	0.2%	1,235	0.3%	1
Greene	213,801	4.1%	12,156	3.0%	0
Henry	20,608	0.4%	1,566	0.4%	1
Hickory	7,541	0.1%	792	0.2%	1
Jasper	93,011	1.8%	7,752	1.9%	0
Lawrence	31,087	0.6%	2,217	0.6%	0
McDonald	17,415	0.3%	1,924	0.5%	0
Newton	45,696	0.9%	3,043	0.8%	0
Polk	22,440	0.4%	1,735	0.4%	1
St Clair	8,695	0.2%	774	0.2%	2
Stone	19,615	0.4%	1,534	0.4%	0
Taney	26,280	0.5%	1,491	0.4%	0
Vernon	19,577	0.4%	1,636	0.4%	1
Webster	24,421	0.5%	1,579	0.4%	0
Total Southwest	**686,493**	**13.1%**	**48,634**	**12.2%**	
Bollinger	10,918	0.2%	799	0.2%	0
Butler	39,856	0.8%	4,823	1.2%	1
Cape Girardeau	63,367	1.2%	3,350	0.8%	0
Carter	5,670	0.1%	852	0.2%	0
Douglas	12,210	0.2%	1,174	0.3%	0
Dunklin	34,044	0.6%	5,609	1.4%	0
Howell	32,332	0.6%	3,357	0.8%	0
Iron	11,028	0.2%	1,512	0.4%	0
Madison	11,440	0.2%	1,150	0.3%	1
Mississippi	14,848	0.3%	2,833	0.7%	0
New Madrid	21,517	0.4%	3,356	0.8%	0
Oregon	9,736	0.2%	1,028	0.3%	0
Ozark	8,840	0.2%	863	0.2%	0
Pemiscot	22,538	0.4%	4,738	1.2%	0
Perry	17,116	0.3%	796	0.2%	0
Reynolds	6,848	0.1%	854	0.2%	0
Ripley	12,649	0.2%	2,344	0.6%	0

Scott	40,484	0.8%	4,955	1.2%	0
Shannon	7,827	0.1%	1,098	0.3%	0
Stoddard	29,708	0.6%	2,637	0.7%	0
Texas	22,080	0.4%	2,202	0.6%	0
Wayne	11,868	0.2%	1,889	0.5%	1
Wright	17,230	0.3%	1,923	0.5%	0
Total Southeast	**464,156**	**8.8%**	**54,144**	**13.5%**	
Total	**5,258,000**	**100.0%**	**399,623**	**100.0%**	

SUMMARY

FIRST YEAR GROUP				
Northwest	1,239,051	23.6%	91,022	22.8%
St. Louis Area	1,907,319	36.3%	139,335	34.9%
TOTAL	**3,146,370**	**59.8%**	**230,357**	**57.6%**
SECOND YEAR GROUP				
Northeast	257,705	4.9%	17,486	4.4%
Central	703,275	13.4%	49,002	12.3%
Southwest	686,493	13.1%	48,634	12.2%
Southeast	464,156	8.8%	54,144	13.5%
TOTAL	**2,111,630**	**40.2%**	**169,266**	**42.4%**
Grand Total	**5,258,000**	**100.0%**	**399,623**	**100.0%**

KEY

(1) Number of HMO licensees: The number of licensed HMO's in each county as of 3/31/93. Source: MO. Dept of Insurance

(2) 1994 General Population: See Appendix Exhibit 3. The 1994 General Population estimate is based on 1993 actual census with 0.46% growth factor for 1994 estimate.

(3) Adjusted Waiver Population: See Appendix 5, Existing Caseload. The Adjusted Waiver Population corresponds to the SFY 1994 population groups to be included in the waiver.

(4) Source for County population: MO Dept of Social Services 1993 Annual Report.

(5) Source for County Title XIX population: MO Dept of Social Services Table 1 data report as of 12/01/93.

5-A. TABLE OF CONTENTS EXISTING CASELOAD

OVERVIEW OF ESTIMATION PROCESS FOR EXISTING CASELOAD

OVERVIEW OF ESTIMATION PROCESS FOR EXISTING CASELOAD

The term "existing caseload" is used to refer to the population that is covered by the current Medicaid program in Missouri. Under the waiver, all acute care services provided to this population will be provided through a managed care entity (with minor exceptions). The existing caseload is comprised of the AFDC, Medicaid for Pregnant Women, Medicaid for Children, other FFP, and Other State eligibility groups. The Aged and Disabled populations are excluded from the waiver program, but will be included in a separate pharmacy managed care network. (A voluntary managed care pilot program will be implemented for the Disabled population.)

To evaluate the financial impact of the Waiver, it was necessary to project the size of the existing caseload during each of the years covered by the waiver, FFY 1996 through FFY 2000. Before outlining the steps used to estimate the existing caseload, two specific caseload issues should be clarified. The first is that the planned phase-in of the the waiver program will result in the partial enrollment of the existing population in the managed care program for the first two years of the waiver. During these two years, the population that is not enrolled in the waiver program will be covered under the existing fee-for-service program. The second caseload issue is that while the Aged and Disabled populations are excluded from the waiver, these two population groups will receive managed pharmacy benefits. Therefore, their caseload has been included to allow the evaluation of the new pharmacy program

Step 1: Select Base Year. The average monthly number of eligibles from SFY 1994 were used as the starting point, or base year, for this projection. The SFY 1994 data consists of six months of actual data and six months of projected data.

Step 2: "Grow" Base Year Estimates from SFY 1994 to First Year of Waiver. It is necessary to grow, or inflate, the average number of monthly eligibles from the base year (SFY 1994) to the first year of the waiver (FFY 1996). There were three options for doing this:

- Assume that the existing caseload will grow at the same rate as in previous years (project into the future based on historical data). Exhibit 1 shows the actual rates of growth for the existing caseload by eligibility group from SFY 1990 through SFY 1994. Both two-year and four-year average growth rates are shown.

- Assume that programmatic changes cause the future growth rates to look different than historical growth rates. Therefore, growth rates based solely on future projections should be used,. Exhibit 2 shows the projected two-year average rates of growth for the Medicaid for Pregnant Women (MPW) and Medicaid for Children (MFC) populations. These projected rates of growth were taken from State budget projections.

- Assume that non-Medicaid-specific growth rates are the most appropriate measures of existing caseload growth. Exhibit 3 shows the projected growth rates for the overall Missouri population from calendar year 1993 to calendar year 2000. The national growth rate in the percentage of the population without health insurance is also shown.

Exhibit 4 summarizes the growth rates from Exhibits 1 and 2. The fifth column of this table, titled "Annual Growth Rates from SFY 1994 to Beginning of Waiver, FFY 1996," shows how the existing population has grown from the base year to the first year of the waiver using a combination of the factors from Exhibits 1 and 2. No single set of factors was selected because of variations in expectations across program categories.

Step 3: "Grow" Existing Caseload Estimates Throughout the Waiver Years. It was assumed that the implementation of the waiver would affect the growth rate of specific populations, and therefore, the same growth rates that were used in Step 2 above were determined not to be appropriate after the implementation of the waiver. The growth rates for the Aged, AFDC Adult and the Disabled groups were assumed to grow at a slightly lower rate after the waiver. The MPW population was assumed to grow at the same rate as the Missouri population because it is not expected that there will be programmatic expansions in this category. The remaining categories are expected to grow at the same rates after the implementation of the waiver. All of the growth rates used throughout the waiver years are shown in the final column of Exhibit 4.

Step 4: Calculate the Average Number of Monthly Eligibles for the Existing Caseload. Using the growth rates selected in Steps 2 and 3 above, the average number of monthly members in the base year, SFY 1994, are then projected forward. Exhibit 5 shows the results of this calculation, overall and by eligibility category.

Step 5: Calculate a Length of Eligibility Adjustment Factor for Each Eligibility Category. A large portion of the existing Medicaid caseload does not have continuous Medicaid coverage. Gaps in coverage occur when recipients exceed the existing Medicaid eligibility criteria. Because the waiver program will significantly raise the eligibility thresholds, the state anticipates fewer gaps in coverage after the waiver's implementation. To reflect the expected increase in the length of eligibility (LOE) for the existing population, an upwards adjustment has been made to the current LOE. With information obtained from SFY 1993 HCFA-2082 data, the LOE for each eligibility

category is adjusted upward by taking one-half the difference between the current existing program LOE and the maximum LOE (or twelve months). Exhibit 6 details the calculation of the LOE adjustment factor.

Step 6: Calculate the Total Number of Member Months for the Existing Caseload, Under the waiver, payments will be made on a capitated basis every month. Therefore, it is necessary to calculate the number of member months for which the state will need to make payments. For example, if three people are enrolled in the program for a year, this represents 36 member months (3 people multiplied by 12 months).

To calculate the number of member months represented by the existing caseload, the annual average number of monthly eligibles were converted into member months by multiplying the annual number of monthly eligibles by twelve months. (NOTE: The annual average number of monthly eligibles is the average of twelve individual monthly counts of eligibles. To convert this to a number that represents a full year, the annual average number of monthly eligibles must be multiplied by twelve.)

To adjust for the expected increase in the length of eligibility for the existing program (see Step 5 above), member months are adjusted upwards for each eligibility group that will be affected by the waiver. Because the Aged and Disabled groups are only included in the pharmacy managed network, and are not impacted by expansions in the Medicaid program, they are excluded from this adjustment. Exhibit 7 shows the existing caseload member months across the waiver years.

Step 7: Calculate the Enrollment of the Existing Disabled Population into the Voluntary Pilot Program. While the pilot program for the disabled will provide coverage for an existing population, implementation of this program is expected to follow similar enrollment patterns as that of the expanded populations. Because the program is voluntary in nature, enrollment rates are expected to be significantly lower even though no premium cost sharing is required by program enrollees. The state of Oregon, in its waiver, assumed that at the end of the first year 70% of the expanded population would be enrolled, and by the end of the second year 90% of the expanded population should be enrolled. In Missouri, however, the enrollment rates are expected to be 50% in FFY 1996, 60% in FFY 1997, 70% in FFY 1998, and 80% in the remaining two years of the waiver.

To calculate the number of member months represented by the existing caseload, it was first necessary to make an assumption about how long this caseload would be eligible. Using the results of step 6 above, the length of eligibility for this group was not expected to exceed 10.2 months, and member months calculations were limited by this expectation.

Based on actual enrollment experience in Oregon, it was assumed that approximately 29% of the expanded population expected at the end of a year would be enrolled within the first three months of that year. Therefore, instead of a linear enrollment process over the waiver years, a curvilinear enrollment was projected for each waiver year. Exhibit 8 shows the enrollment of this population throughout the waiver years.

APPENDIX 5.A

EXHIBIT 1

EXISTING CASELOAD: ACTUAL RATES OF GROWTH

AVERAGE NUMBER OF MONTHLY ELIGIBLES (1)

	SFY 1990 MEMBERS	SFY 1991 MEMBERS	SFY 1992 MEMBERS	SFY 1993 MEMBERS	SFY 1994 MEMBERS
Aged (2)	49,286	58,590	58,993	58,979	64,034
AFDC	207,676	227,322	258,735	270,291	273,546
Disabled (3)	56,495	56,149	59,024	67,747	73,993
Medicaid Pregnant Women (MPW)	3,692	5,983	7,808	8,993	9,107
Medicaid for Children (MFC), (4)	12,541	28,206	50,199	72,339	94,540
Mandated Expansion Group (MFC)	*1,500*	*14,041*	*29,344*	*46,631*	*69,862*
Core Group (MFC)	*11,041*	*14,165*	*20,855*	*25,708*	*24,678*
Other FFP	6,477	9,974	13,345	13,691	14,563
Other State	8,273	7,380	6,751	7,414	7,867
**Totals **	344,440	393,604	454,855	499,454	537,650

PERCENTAGE CHANGE FROM PREVIOUS YEAR (5)

	SFY 1990 MEMBERS	SFY 1991 MEMBERS	SFY 1992 MEMBERS	SFY 1993 MEMBERS	SFY 1994 MEMBERS	4-YR AVERAGE CHANGE: SFY 1991 - SFY 1994	2-YR AVERAGE CHANGE: SFY 1993 - SFY 1994
Aged		18.9%	0.7%	0.0%	8.6%	7.0%	4.3%
AFDC		9.5%	13.8%	4.5%	1.2%	7.2%	2.8%
Disabled		-0.6%	5.1%	14.8%	9.2%	7.1%	12.0%
Medicaid Pregnant Women (MPW)		62.1%	30.5%	15.2%	1.3%	27.3%	8.2%
Medicaid for Children (MFC), (4)		124.9%	78.0%	44.1%	30.7%	69.4%	37.4%
Mandated Expansion Group (MFC)		*836.1%*	*109.0%*	*58.9%*	*49.8%*	*263.4%*	*54.4%*
Core Group (MFC)		*28.3%*	*47.2%*	*23.3%*	*-4.0%*	*23.7%*	*9.6%*
Other FFP		54.0%	33.8%	2.6%	6.4%	24.2%	4.5%
Other State		-10.8%	-8.5%	9.8%	6.1%	-0.8%	8.0%
Totals		14.3%	15.6%	9.8%	7.6%	11.8%	8.7%

(1) Source: This data was compiled using the State of Missouri's Medicaid program data (Final numbers were provided 5/9/94).

(2) Medicare Dual Eligibles, SLMBs, and QMBs are included in these counts but will be excluded from the waiver program. However, these members will be included in the estimates of the pharmacy managed care network costs.

(3) The disabled population will be excluded from the waiver population. However, these members will be included in the estimates of the pharmacy managed care network costs. The cost of a voluntary pilot program for the disabled is evaluated separately.

(4) Legislative Group represents monthly eligibles resulting from Medicaid program changes.
Core Group represents monthly eligibles enrolled because of the existing (previous year's) program eligibility requirements.

(5) Both a two-year and a four-year average annual change were calculated for informational purposes.

APPENDIX 5.A

EXHIBIT 2

EXISTING CASELOAD:
RATES OF GROWTH FOR MEDICAID FOR PREGNANT WOMEN (MPW) AND
MEDICAID FOR CHILDREN (MFC) BASED ON STATE BUDGET PROJECTIONS

AVERAGE NUMBER OF MONTHLY ELIGIBLES (1)

	SFY 1994 MEMBERS	SFY 1995 MEMBERS	SFY 1996 MEMBERS
Medicaid Pregnant Women (MPW)	9,107	11,007	12,907
Medicaid for Children (MFC)	94,540	105,540	116,540

PERCENTAGE CHANGE FROM PREVIOUS YEAR

	SFY 1994 MEMBERS	SFY 1995 MEMBERS	SFY 1996 MEMBERS	2-YR AVERAGE CHANGE
Medicaid Pregnant Women (MPW), (2)		20.9%	17.3%	19.1%
Medicaid for Children (MFC), (3)		11.6%	10.4%	11.0%

(1) Source: See Exhibit 1.

(2) The program is not expected to grow at a rate that is comparable to previous trends. For budget projections it was assumed that 3,800 more women would be eligible between 1994 and 1996, so a growth rate of 19.1 percent is used.

(3) The program is not expected to grow at a rate that is comparable to previous trends. For budget projections it was assumed that 22,000 more children would be eligible between 1994 and 1996, so a growth rate of 11.0 percent is used.

APPENDIX 5.A

EXHIBIT 3

EXISTING CASELOAD:
CALENDAR YEAR (CY) OVERALL MISSOURI POPULATION AND UNINSURED GROWTH RATES

GROWTH OF UNINSURED - ALL STATES (1)

	CY 1990	CY 1991	CY 1992	2-YR AVERAGE CHANGE
Percent Uninsured	13.9	14.1	14.7	
Percentage Change		1.4%	4.3%	2.8%

POPULATION GROWTH

	CY 1993 ACTUAL CENSUS (1)	CY 1994 EST.	CY 1995 EST.	CY 1996 EST.	CY 1997 EST.	CY 1998 EST.	CY 1999 EST.	CY 2000 CENSUS PROJECTION (1)
Population Growth	5,234,000	5,258,000	5,282,000	5,306,000	5,330,000	5,354,000	5,378,000	5,402,000
Percentage Change		0.46%	0.46%	0.45%	0.45%	0.45%	0.45%	0.45%
Percentage Change Including Average Growth of Uninsured (2)		3.32%	3.32%	3.31%	3.31%	3.31%	3.31%	3.31%

(1) Source: Obtained from the U.S. Census Bureau 4/11/94

(2) The annual average compounded growth rate, population and uninsured, from 1993 to 2000 is: 3.31%

APPENDIX 5.A

EXHIBIT 4

EXISTING CASELOAD:
SELECTION OF RATES OF GROWTH USED IN WAIVER ESTIMATES

	ACTUAL PROGRAMMATIC RATES OF GROWTH		BUDGETED GROWTH RATES	RATES OF GROWTH USED IN WAIVER ESTIMATES	
	4-YR AVERAGE CHANGE SFY 1991 - 1994 (1)	2-YR AVERAGE CHANGE SFY 1993 - 1994 (2)	2-YR AVERAGE CHANGE SFY 1995 - 1996	ANNUAL GROWTH RATES FROM SFY 1994 TO BEGINNING OF WAIVER, FFY 1996	ANNUAL GROWTH RATES THROUGHOUT WAIVER YEARS, FFY 1996 - FFY 2000
Aged	7.0%	4.3%		7.0% (1)	6.0% (5)
AFDC	7.2%	2.8%		2.8% (2)	2.5% (5)
Disabled	7.1%	12.0%		7.1% (1)	6.5% (5)
Medicaid Pregnant Women (MPW)	27.3%	8.2%	19.1% (3)	19.1% (3)	0.5% (6)
Medicaid for Children (MFC)	69.4%	37.4%	48.4% (4)	11.0% (3)	11.0% (3)
Other FFP	24.2%	4.5%		4.5% (2)	4.5% (2),(7)
Other State	-0.8%	8.0%		8.0% (2)	8.0% (2),(7)

(1) For calculation of values see Exhibit 1, 4-YR AVERAGE CHANGE Column.

(2) For calculation of values see Exhibit 1, 2-YR AVERAGE CHANGE Column.

(3) Represents the 2-year budget projection (See Exhibit 2).

(4) Value based on the combined increase for programmatic and budget changes. See Exhibit 1 and 2.

(5) Values adjusted from actual computed growth rates because of expected changes in Missouri's demographics.

(6) The annual growth rate for the Missouri population is used because the Medicaid program is projected to cover 45 percent of all births in each of the two years immediately proceeding the waiver and this percentage is not expected to increase during the waiver years. For calculation of values see Exhibit 3.

(7) Future growth rates are expected to reflect the 2-year historical trends.

APPENDIX 5.A

EXHIBIT 5

EXISTING CASELOAD:
AVERAGE NUMBER OF MONTHLY ELIGIBLES

Eligibility Category	Average Number of Monthly Members (1)	SFY 1994 - End of FFY 1995: Rate of Growth		FFY 1996 - FFY 2000: Growth of Monthly Members for Waiver Years					
	SFY 1994	ANNUAL Growth Rate (2)	FFY 1995 (3)	ANNUAL Growth Rate (4)	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Aged	64,034	7.0%	69,708	6.0%	73,891	78,324	83,023	88,005	93,285
AFDC	273,546	2.8%	283,275	2.5%	290,357	297,616	305,056	312,683	320,500
Disabled	73,993	7.1%	80,642	6.5%	85,884	91,466	97,412	103,743	110,487
Medicaid Pregnant Women (MPW)	9,107	19.1%	11,326	0.5%	11,378	11,429	11,481	11,533	11,586
Medicaid for Children (MFC)	94,540	11.0%	107,748	11.0%	119,632	132,826	147,475	163,740	181,799
Other FFP	14,563	4.5%	15,383	4.5%	16,073	16,793	17,545	18,331	19,153
Other State	7,867	8.0%	8,658	8.0%	9,348	10,092	10,896	11,764	12,701
Baseline Totals (5)	399,623		426,391		446,787	468,756	492,454	518,051	545,738
SecureCare Totals (5), (6)	399,623		426,391		258,511	468,756	492,454	518,051	545,738

(1) Source: See Exhibit 1.

(2) For the selection of Rates of Growth used in Waiver Estimates see Exhibit 4, ANNUAL GROWTH RATES FROM SFY 1994 TO BEGINNING OF WAIVER, FFY 1996 column.

(3) Total inflation rate used for SFY 1994 to FFY 1995 based on 15 months of inflation.

(4) For the selection of Rates of Growth used in Waiver Estimates see Exhibit 4, ANNUAL GROWTH RATES THROUGHOUT WAIVER YEARS, FFY 1996 - FFY 2000 column.

(5) Totals exclude Aged and Disabled populations. Totals with Waiver are the eligibles that will be included in the Waiver managed care program.

(6) Phase-in of population occurs in waiver years 1-3. Waiver year 1 (57.86%), NW and St. Louis regions.
Waiver year 2 (additional 42.14%), NE, Central, SW, and SE regions.

APPENDIX 5.A

EXHIBIT 6

EXISTING CASELOAD:
AVERAGE MONTHS OF ELIGIBILITY ADJUSTMENT CALCULATION (1)

	Unduplicated Total Number of Eligibles	Number Eligible for Full Year	Number Eligible for Partial Year	Number of Covered Months for Partial Year Eligibles	Average Months of Eligibility (3)	Difference: Average Length of Elig. minus 12 (Max. LOE)	Percentage Adjustment (1/2 of Difference)	Expected Average LOE under Program Expansion
Aged	84,780	56,773	28,007	158,142	9.90	2.10	10.6%	10.95
AFDC	139,243	72,011	67,232	394,145	9.04	2.96	16.4%	10.52
Disabled	95,286	66,968	28,318	163,889	10.15	1.85	9.1%	11.08
Medicaid Pregnant Women (MPW)	32,308	2,081	30,227	169,347	6.01	5.99	49.8%	9.01
Medicaid for Children (MFC)	354,743	224,842	129,901	795,745	9.85	2.15	10.9%	10.92
Other FFP (2)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other State (2)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Totals	706,360	422,675	283,685	1,681,268	9.56	2.44	12.8%	10.78

(1) Source: SFY 1993 HCFA-2082 Form.

(2) The breakout of Other FFP and Other State categories was not possible for this data source, Total Average Months of Eligibility will be used in subsequent tables.

(3) Average Months of Eligibility calculated in the following manner:

A. Determine Months of Eligibility: (No. of Eligibles for a Full Year x 12) plus (Number of Covered Months for Partial Year Eligibles)

B. Compute Total No. of Eligibles: No. of Eligibles for Full Year plus Number of Eligibles for Partial Year

C. Compute the quotient of A/B.

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APPENDIX 5.A

EXHIBIT 7

EXISTING CASELOAD:
TOTAL NUMBER OF MEMBER MONTHS

Eligibility Category	Average Number of Monthly Eligibles	Length of Eligibility Percent Adjustment (1)	Total Member Months (2)	FFY 1996 - FFY 2000: Growth of Total Member Months for Waiver Years					
	FFY 1995		FFY 1995	ANNUAL Growth Rate (3)	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Aged	69,708	N/A	836,497	6.0%	886,687	939,888	996,281	1,056,058	1,119,421
AFDC	283,275	16.4%	3,956,682	2.5%	4,055,599	4,156,989	4,260,914	4,367,436	4,476,622
Disabled	80,642	N/A	967,706	6.5%	1,030,607	1,097,596	1,168,940	1,244,921	1,325,841
Medicaid Pregnant Women (MPW)	11,326	49.8%	203,547	0.5%	204,469	205,396	206,328	207,263	208,203
Medicaid for Children (MFC)	107,748	10.9%	1,434,176	11.0%	1,592,351	1,767,970	1,962,958	2,179,452	2,419,822
Other FFP	15,383	12.8%	208,146	4.5%	217,473	227,218	237,400	248,037	259,152
Other State	8,658	12.8%	117,149	8.0%	126,480	136,555	147,432	159,175	171,854
Baseline Totals (4)	426,391		5,919,700		6,196,372	6,494,128	6,815,031	7,161,364	7,535,653
SecureCare Totals (4), (5)	426,391		5,919,700		3,585,221	6,494,128	6,815,031	7,161,364	7,535,653

(1) Adjustment based on 1/2 the difference in existing length of eligibility and 12 months of eligibility.
Aged and Disabled categories are not adjusted. See Exhibit 6 for calculation of adjustment percentages.

(2) The calculation of Total Member Months is the product of Full Year Equivalent Length of Eligibility (12 months), Average Number of Monthly Eligibles (See Exhibit 5 for calculation of Average Number of Monthly Eligibles), and Length of Eligibility adjustment (see Exhibit 7).

(3) For the selection of rates of growth used in waiver estimates see Exhibit 4, ANNUAL GROWTH RATES THROUGHOUT WAIVER YEARS, FFY 1996 - FFY 2000 column.

(4) Totals exclude Aged and Disabled populations. Totals with Waiver are the months that will be included in the SecureCare managed care program.

(5) Phase-in of population occurs in waiver years 1-3. Waiver year 1 (57.86%), NW and St. Louis regions.
Waiver year 2 (additional 42.14%), NE, Central, SW, and SE regions.

APPENDIX 5.A

EXHIBIT 8

EXISTING CASELOAD:
PORTION OF EXISTING DISABLED POPULATION EXPECTED TO ENROLL IN THE VOLUNTARY DISABLED MANAGED CARE PILOT PROGRAM

	Disabled Pilot Population (1)	Expected Presentation Rate By End of Year	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members	Cumulative Member Months (2)
Waiver Year 1: FFY 1996	2,192	50%	1,096	1	0.08971	98	98
Rate of enrollment based on				2	0.18747	205	304
Oregon experience.				3	0.29400	322	626
(1st 3 months) 29.4%				4	0.35515	389	1,015
				5	0.42003	460	1,476
Missouri increase in				6	0.48889	536	2,012
population.				7	0.56195	616	2,628
				8	0.63948	701	3,329
				9	0.72175	791	4,120
No Geographic Phase-in				10	0.80905	887	5,007
				11	0.90169	988	5,995
				12	1.00000	1,096	7,091
Waiver Year 2: FFY 1997	2,335	60%	1,401	1	0.08971	1,123	1,057
Rate of enrollment based on				2	0.18747	1,153	2,141
Oregon experience and				3	0.29400	1,186	3,256
increase in population.				4	0.35515	1,204	4,389
				5	0.42003	1,224	5,540
				6	0.48889	1,245	6,711
				7	0.56195	1,267	7,903
				8	0.63948	1,291	9,117
				9	0.72175	1,316	10,355
No Geographic Phase-in				10	0.80905	1,343	11,617
				11	0.90169	1,371	12,906
				12	1.00000	1,401	14,224
Waiver Year 3: FFY 1998	2,487	70%	1,741	1	0.08971	1,431	1,331
Rate of enrollment based on				2	0.18747	1,465	2,693
Oregon experience and				3	0.29400	1,501	4,088
increase in population.				4	0.35515	1,522	5,303
				5	0.42003	1,544	6,938
				6	0.48889	1,567	8,395
				7	0.56195	1,592	9,875
				8	0.63948	1,618	11,379
				9	0.72175	1,646	12,909
No Geographic Phase-in				10	0.80905	1,676	14,468
				11	0.90169	1,707	16,055
				12	1.00000	1,741	17,673

(1) Values inflated from FFY 1994 through waiver years, see Existing Caseload Appendix, Exhibit 4.

(2) Because eligibles represent point in time estimates instead of the average monthly eligibles for the year, values are adjusted by the expected length of eligibility (rather than 12 months) derived from HCFA-2082 Disabled length of eligibility estimates (see Existing Caseload, Exhibit 6): 10.2

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APPENDIX 5.A

EXHIBIT 8

EXISTING CASELOAD:
PORTION OF EXISTING DISABLED POPULATION EXPECTED TO ENROLL IN THE VOLUNTARY DISABLED MANAGED CARE PILOT PROGRAM

	Disabled Pilot Population (1)	Expected Presentation Rate By End of Year	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members	Cumulative Member Months (2)
Waiver Year 4: FFY 1999	2,648	80%	2,119	1	0.08333	1,772	1,633
Rate of enrollment based on				2	0.16667	1,804	3,295
annual population increase				3	0.25000	1,835	4,986
distributed equally over				4	0.33333	1,867	6,706
12 months.				5	0.41667	1,898	8,455
				6	0.50000	1,930	10,233
				7	0.58333	1,961	12,040
				8	0.66667	1,993	13,876
				9	0.75000	2,024	15,741
No Geographic Phase-in				10	0.83333	2,056	17,635
				11	0.91667	2,087	19,559
				12	1.00000	2,119	21,511
Waiver Year 5: FFY 2000	2,820	85%	2,397	1	0.08333	2,142	1,914
Rate of enrollment based on				2	0.16667	2,165	3,849
annual population increase				3	0.25000	2,188	5,805
distributed equally over				4	0.33333	2,211	7,781
12 months.				5	0.41667	2,235	9,779
				6	0.50000	2,258	11,797
				7	0.58333	2,281	13,835
				8	0.66667	2,304	15,895
No Geographic Phase-in				9	0.75000	2,328	17,975
				10	0.83333	2,351	20,076
				11	0.91667	2,374	22,198
				12	1.00000	2,397	24,341

(1) Values inflated from FFY 1994 through waiver years, see Existing Caseload Appendix, Exhibit 4.

(2) Because eligibles represent point in time estimates for the year, values are adjusted by the expected length of eligibility values are adjusted by the expected length of eligibility (rather than 12 months) derived from HCFA-2082 Disabled length of eligibility estimates (see Existing Caseload, Exhibit 6): 10.2

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5-B. TABLE OF CONTENTS EXPANDED CASELOAD AND TOTAL WAIVER POPULATION

OVERVIEW OF ESTIMATION PROCESS FOR EXPANDED CASELOAD

OVERVIEW OF ESTIMATION PROCESS FOR EXPANDED CASELOAD

The term "expanded caseload" is used to refer to the population in Missouri that is under 200% FPL and is currently uninsured. This population under 200% FPL can be divided into three eligibility groups: children under 200% FPL, adults under 100% FPL, and adults between 100-200% FPL. These three groups will be added to the existing Medicaid population for inclusion in the waiver program

Step 1: **Determine Size of Expanded Population in Base Year.** The 1993 Current Population Survey (CY 1992 data) conducted by the U.S. Census Bureau was used to estimate the size of the uninsured population in Missouri. ***Exhibit 1*** shows the total uninsured population in Missouri by age. ***Exhibit 2*** shows the population under 200% FPL by age within three groups: (1) Under 100% FPL; (2) 100% FPL - 149% FPL; and (3) 150% FPL - 199% FPL. The following two adjustments were made to the CPS information on Exhibit 2:

- Because Medicaid coverage has increased by an additional 40,500 people since the CPS data was collected, the number of uninsured were reduced accordingly.

- Because the available Missouri specific analysis of the Census Bureau categorization for children (Under 20 years of age) does not correspond to the eligibility category of children in Missouri (Under 21 years of age), an adjustment was made to the Census data.

At the bottom of Exhibit 2, the "target population" is shown. This is the expanded population of eligibles based on the waiver program's eligibility criteria.

Step 2: **"Grow" Base Year Estimates from 1992 to the End of the Waiver.** It is necessary to grow, or inflate, the average number of monthly eligibles for the expanded population from the base year (CY 1992) to the first year of the waiver (FFY 1996) as well as throughout the waiver years. It was assumed that the population under 200% FPL would grow at a rate that reflects the overall projected growth in the Missouri population compounded by the percentage of uninsured in the state. This compounded rate was calculated using the census projections for the growth of the Missouri population and historical data for the national growth of the uninsured. The rate, 3.31% annually, was used to inflate the expanded caseload both before and after the implementation of the waiver (for the calculation of the Missouri population growth and the growth of the uninsured, see Appendix 5A, Exhibit 3). ***Exhibit 3*** of this section shows the uninsured populations projected forward across the waiver years.

Step 3: **Calculate the Rate of Enrollment for the Expanded Population.** It was necessary to estimate how quickly the expanded eligibility groups would enroll in the waiver program. Missouri expects to begin enrollment of children under 200% FPL and adults under 100% FPL in FFY 1996, and adults between 100-200% FPL in FFY 1997. The State of Oregon, in its waiver, assumed that at the end of the first year 70% of the expanded population would be enrolled, and by the end of the second year 90% of the expanded population would be enrolled.

The waiver program's enrollment, however, will be affected by premium cost sharing for the uninsured populations between 100-200% FPL. Premium cost sharing requirements are expected to reduce the rate of enrollment. However, this impact will vary across the three groups within the expanded population:

- Because only part of the child population under 200% FPL is impacted by premium cost sharing (i.e., children between 100-200% FPL), presentation rates are weighted by the number of eligibles above and below 100% FPL for this population. Premium cost sharing is expected to result in 60% of children under 200% FPL to enroll at the end of first year, FFY 1996; 70% at the end of the second waiver year; and 80% in all remaining waiver years.

- The population of uninsured adults between 100-200% FPL implemented in FFY 1997 is also impacted by premium cost sharing. Consequently, enrollment rates are expected to be significantly lower than the other waiver groups that are either partially impacted (i.e., children under 200% FPL) or unaffected (i.e., adults under 100% FPL) by premium cost sharing. The show rate for this uninsured group is assumed to be 50% at the end of the first year; 60% at the end of the second year; and 70% for FFY 1999 and FFY 2000.

- For the adult population under 100% FPL that begins enrollment in FFY 1996, projections for this expanded population assumes that 70% would enroll by the end of the first year; 80% by the end of the second year; and 90% for the three remaining waiver years.

In addition to the show rate, the enrollment of the Missouri population into the waiver program will be limited by the geographic phase-in of the program. The state expects that all regions of the state will be participating in the expanded program by the beginning of FFY 1997. In FFY 1996, phase-in of the Northwest and St. Louis regions for children under 200% FPL and adults under 100% FPL occurs, which represents 59.8% of the total population expected to enroll across the State. In FFY 1997, along with the implementation of the adult population between 100-200% FPL, the Northeast, Central, Southwest, and Southeast regions are included in the expanded program, bringing the expected enrollment percentage to 100% of the total statewide population expected to enroll.

Based on actual enrollment experience in Oregon, it was assumed that approximately 29% of the expanded population expected at the end of a year would be enrolled within the first three months of that year. Therefore, instead of a linear enrollment process over the waiver years, a curvilinear enrollment was projected for each waiver year. However, because of the phase-in of the program, the enrollment rate is not as steep as Oregon's experience. ***Exhibits 4, 5, and 6*** show the enrollment of the expanded population for the three eligibility groups.

To visually examine the enrollment rate resulting from the above assumptions, ***Exhibit 8*** shows the enrollment curve associated with the estimated rate of enrollment for the expanded populations. The ***Exhibit 9*** chart compares the projected enrollment of the waiver program with that of the baseline Medicaid program.

Step 4: **Enrollment of 1902(r)(2) and Disabled Pilot Populations.** Two additional population enrollments were modeled for the waiver: (1) the 1902(r)(2) population without the waiver, and (2) the portion of the existing disabled population that is expected to enroll in the voluntary disabled pilot program.

The CPS data was also used to estimate the expansion that the State anticipates will occur without the waiver. Enrollment for this population is expected to reflect the same show rates as would occur with the implementation of the waiver; 70% in the first year; 80% in the second year; and 90% in the remaining three years. ***Exhibit 7*** shows the enrollment of the 1902(r)(2) population assuming the absence of the waiver program. The baseline enrollment for this population was calculated with no geographic phase-in or premium cost sharing requirement, and will be used in Appendix D tables for estimating the financial impacts of the waiver.

Step 5: **Calculate the Number of Member Months for the Expanded Population and Disabled Pilot Program.** Under the waiver, payments will be made on a capitated basis every month. Therefore, it is necessary to calculate the number of member months for which the state will need to make payments. For example, if three people are enrolled in the program for a year, this represents 36 member months (3 people multiplied by 12 months).

To calculate the number of member months represented by the existing caseload, it was first necessary to make an assumption about how long this caseload would be eligible. It was assumed that the eligibility of the new populations would reflect the length of eligibility (LOE) for the existing caseload categories after the adjustment for expected increased in eligibility (see Appendix 5A, Exhibits 6 and 7). For children under 200% FPL, the length of eligibility is expected to be 10.9 months (Medicaid for Children Adjusted LOE), per year, while LOE for adults under 100% FPL and adults between 100-200% FPL is expected to be 10.5 months (AFDC Adjusted LOE) per year. All member month calculations are limited by the projected lengths of eligibility.

For example, the first year of the waiver it is assumed that 8,621 children under 200% FPL be enrolled in the second month of the waiver, which results in total cumulative member months of 21,600 (4,125 children eligible one month and 8,621 children eligible for two months. 4,125 months plus 8,621 months equals 12,746).

Exhibits 4, 5, and 6 display the estimation process for the enrollment of the three expanded populations under the waiver. Because the Medicaid program is expected to expand under 1902(r)(2) without the implementation of the waiver, enrollment of children under 200% FPL was also determined, which assumes no managed care geographic phase-in or premium cost sharing, because this population would continue to utilize the current fee-for-service system. ***Exhibit 7*** displays the expected baseline enrollment of the 1902(r)(2) population.

Exhibit 10 presents a summary of the expanded caseload, showing the number of member months for the uninsured population groups under 200% FPL.

APPENDIX 5.B

EXHIBIT 1

EXPANDED CASELOAD:
TOTAL UNINSURED PERSONS IN MISSOURI
BY AGE AND POVERTY LEVEL (1)

Age	Poverty Level	CY 1992 Total
Under 20	BELOW POV	82,536
	100-149%	39,220
	150-199%	24,917
	200-299%	24,604
	300%+	22,190
20-24	BELOW POV	16,653
	100-149%	10,055
	150-199%	8,707
	200-299%	17,001
	300%+	23,753
25-34	BELOW POV	28,323
	100-149%	25,805
	150-199%	19,041
	200-299%	32,219
	300%+	31,161
35-44	BELOW POV	24,486
	100-149%	18,555
	150-199%	15,469
	200-299%	18,574
	300%+	15,292
45-54	BELOW POV	18,641
	100-149%	11,374
	150-199%	6,839
	200-299%	11,665
	300%+	11,846
55-64	BELOW POV	11,047
	100-149%	5,460
	150-199%	4,467
	200-299%	4,632
	300%+	2,938
65 and over	ALL LEVELS	3,326
TOTAL		590,796

(1) Source: 1993 CPS Data Tape (CY 1992 Data). Note: Data represents all uninsured in the State. See Exhibit 2 for uninsured persons considered for coverage under the expanded program.

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APPENDIX 5.B

EXHIBIT 2

EXPANDED CASELOAD:
DISTRIBUTION OF EXPANDED CASELOAD
BY AGE AND POVERTY LEVEL GROUPS (1)

Poverty Level	Age	Total	Coverage Adjusted Total (2)	Volume Adjusted Total (3)
BELOW POV	UNDER 20	82,536	55,806	59,137
	20-24	16,653	16,653	13,322
	25-34	28,323	28,323	28,323
	35-44	24,486	24,486	24,486
	45-54	18,641	18,641	18,641
	55-64	11,047	11,047	11,047
	Sub-Total	181,686	154,956	154,956
100-149%	UNDER 20	39,220	25,450	27,461
	20-24	10,055	10,055	8,044
	25-34	25,805	25,805	25,805
	35-44	18,555	18,555	18,555
	45-54	11,374	11,374	11,374
	55-64	5,460	5,460	5,460
	Sub-Total	110,469	96,699	96,699
150-199%	UNDER 20	24,917	24,917	26,658
	20-24	8,707	8,707	6,966
	25-34	19,041	19,041	19,041
	35-44	15,469	15,469	15,469
	45-54	6,839	6,839	6,839
	55-64	4,467	4,467	4,467
	Sub-Total	79,440	79,440	79,440
Totals		371,595	331,095	331,095

Age	Target Population	Total (3)
Under 21	Under 200%	113,256
Adults 21-64	Under 100%	95,819
	100 - 200%	122,020

(1) Source: 1993 CPS Data Tape (CY 1992 Data)

(2) Because Medicaid coverage has increased by an additional 40,500 people since the compilation of this data source, the number of uninsured, represented by this table, is decreased accordingly.

(3) 20% of persons between the Ages of 20-24 for each poverty level on this table are moved to the UNDER 20 category.

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APPENDIX 5.B

EXHIBIT 3

EXPANDED CASELOAD:
TARGET UNINSURED POPULATION ACROSS WAIVER YEARS (1), (2)

	Growth Rate	CY 1992	FFY 1993	FFY 1994	FFY 1995	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Number of Uninsured Children (Under 21 years of age) Under 200% FPL	3.31%	113,256	116,059	119,904	123,877	127,982	132,222	136,603	141,129	145,806
Number of Uninsured Adults under 100% FPL	3.31%	95,819	98,191	101,444	104,805	108,278	111,866	115,572	119,402	123,358
Number of Uninsured Adults between 100% to 200% FPL	3.31%	122,020	125,039	129,182	133,463	0 (3)	142,453	147,173	152,050	157,088
Total Expanded Waiver Population	3.31%	331,095	339,289	350,531	362,145	236,260	386,541	399,349	412,581	426,251

(1) Assumes annual growth rate of: 3.31%
This annual rate is based on the projected growth of the Missouri population between 1990 and 2000 and the growth of uninsured (All States) between 1990 and 1992. See Existing Caseload Appendix, Exhibit 3 for calculation.

(2) Approximately 3,326 people 65 years and older are not reflected in this chart. Estimates for increasing the Medicare buy-in population are currently in progress.

(3) Phase-in of coverage for Adults between 100-200% FPL occurs in Year 2: FFY 1997 of the Waiver.

APPENDIX 5.B

EXHIBIT 4

EXPANDED CASELOAD:
EXPECTED ENROLLMENT OF UNINSURED POPULATION OF CHILDREN
UNDER 200% FPL FOR WAIVER YEARS

	Children Under 200% FPL	Expected Presentation Rate By End of Year (1)	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members	Cumulative Member Months (2)
Waiver Year 1: FFY 1996	127,982	60%	45,611	1	0.08971	4,092	4,092
Rate of enrollment based on				2	0.18747	8,551	12,643
Oregon experience.				3	0.29400	13,410	26,052
(1st 3 months) 29.4%				4	0.35515	16,199	42,251
				5	0.42003	19,158	61,409
Missouri increase in				6	0.48889	22,299	83,708
population.				7	0.56195	25,631	109,339
				8	0.63948	29,168	138,507
Geographic phase-in of				9	0.72175	32,920	171,427
Northwest and St. Louis				10	0.80905	36,902	208,329
regions: 59.8%				11	0.90169	41,127	249,456
				12	1.00000	45,611	295,068
Waiver Year 2: FFY 1997	132,222	70%	91,970	1	0.08971	49,770	49,770
Rate of enrollment based on				2	0.18747	54,302	104,072
Oregon experience.				3	0.29400	59,241	163,313
				4	0.35515	62,075	225,388
Missouri increase in				5	0.42003	65,083	290,472
population.				6	0.48889	68,275	358,747
				7	0.56195	71,662	430,410
Additional phase-in of				8	0.63948	75,257	505,666
Northeast, Central, Southwest,				9	0.72175	79,071	584,737
and Southeast regions: 100.0%				10	0.80905	83,118	667,855
				11	0.90169	87,413	755,267
				12	1.00000	91,970	847,237
Waiver Year 3: FFY 1998	136,603	80%	108,677	1	0.08971	93,469	91,581
Rate of enrollment based on				2	0.18747	95,102	184,761
Oregon experience.				3	0.29400	96,882	279,686
				4	0.35515	97,903	375,612
Missouri increase in				5	0.42003	98,988	472,600
population.				6	0.48889	100,138	570,715
				7	0.56195	101,359	670,026
Statewide geographic				8	0.63948	102,654	770,606
coverage: 100.0%				9	0.72175	104,029	872,534
				10	0.80905	105,487	975,890
				11	0.90169	107,035	1,080,763
				12	1.00000	108,677	1,187,245

(1) Presentation rates are weighted by the number of enrollees expected under 100% FPL and between 100-200% FPL.

(2) Expected length of eligibility based on adjusted existing caseload length of eligibility (see Existing Caseload, Exhibit 6): 10.9

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APPENDIX 5.B

EXHIBIT 4

EXPANDED CASELOAD:
EXPECTED ENROLLMENT OF UNINSURED POPULATION OF CHILDREN
UNDER 200% FPL FOR WAIVER YEARS

	Children Under 200% FPL	Expected Presentation Rate By End of Year (1)	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members	Cumulative Member Months (2)
Waiver Year 4: FFY 1999	141,129	80%	112,278	1	0.08333	108,978	100,690
Rate of enrollment based on				2	0.16667	109,278	201,658
annual population increase				3	0.25000	109,578	302,903
distributed equally over				4	0.33333	109,878	404,425
12 months.				5	0.41667	110,178	506,224
				6	0.50000	110,478	608,301
Statewide geographic				7	0.58333	110,778	710,654
coverage: 100.0%				8	0.66667	111,078	813,286
				9	0.75000	111,378	916,194
				10	0.83333	111,678	1,019,379
				11	0.91667	111,978	1,122,842
				12	1.00000	112,278	1,226,582
Waiver Year 5: FFY 2000	145,806	80%	115,999	1	0.08333	112,588	104,027
Rate of enrollment based on				2	0.16667	112,898	208,340
annual population increase				3	0.25000	113,208	312,939
distributed equally over				4	0.33333	113,518	417,825
12 months.				5	0.41667	113,828	522,997
				6	0.50000	114,138	628,456
Statewide geographic				7	0.58333	114,448	734,201
coverage: 100.0%				8	0.66667	114,758	840,233
				9	0.75000	115,068	946,551
				10	0.83333	115,378	1,053,155
				11	0.91667	115,689	1,160,046
				12	1.00000	115,999	1,267,224

(1) Presentation rates are weighted by the number of enrollees expected under 100% FPL and between 100-200% FPL.

(2) Expected length of eligibility based on adjusted existing caseload length of eligibility (see Existing Caseload, Exhibit 6): 10.9

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APPENDIX 5.B

EXHIBIT 5

EXPANDED CASELOAD:
EXPECTED ENROLLMENT OF UNINSURED ADULT POPULATION
UNDER 100% FPL FOR WAIVER YEARS

	Uninsured Population Under 100% FPL	Expected Presentation Rate By End of Year	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members (1)	Cumulative Member Months (1)
Waiver Year 1: FFY 1996	108,278	70%	45,355	1	0.08971	4,069	4,069
Rate of enrollment based on				2	0.18747	8,503	12,572
Oregon experience.				3	0.29400	13,335	25,906
(1st 3 months) 29.4%				4	0.35515	16,108	42,014
				5	0.42003	19,051	61,065
Missouri increase in				6	0.48889	22,174	83,239
population.				7	0.56195	25,487	108,726
				8	0.63948	29,004	137,730
Geographic phase-in of				9	0.72175	32,735	170,465
Northwest and St. Louis				10	0.80905	36,695	207,160
regions: 59.8%				11	0.90169	40,897	248,057
				12	1.00000	45,355	293,413
Waiver Year 2: FFY 1997	111,866	80%	89,493	1	0.08971	49,315	49,315
Rate of enrollment based on				2	0.18747	53,630	102,945
Oregon experience.				3	0.29400	58,332	161,277
				4	0.35515	61,031	222,307
Missouri increase in				5	0.42003	63,894	286,202
population.				6	0.48889	66,933	353,135
				7	0.56195	70,158	423,294
Additional phase-in of				8	0.63948	73,580	496,874
Northeast, Central, Southwest,				9	0.72175	77,211	574,085
and Southeast regions: 100.0%				10	0.80905	81,065	655,150
				11	0.90169	85,154	740,304
				12	1.00000	89,493	829,796
Waiver Year 3: FFY 1998	115,572	90%	104,015	1	0.08971	90,795	82,327
Rate of enrollment based on				2	0.18747	92,215	165,942
Oregon experience.				3	0.29400	93,762	250,960
				4	0.35515	94,650	336,783
Missouri increase in				5	0.42003	95,592	423,460
population.				6	0.48889	96,592	511,044
				7	0.56195	97,653	599,590
Statewide geographic				8	0.63948	98,779	689,156
coverage: 100.0%				9	0.72175	99,974	779,807
				10	0.80905	100,000	870,480
				11	0.90169	100,000	961,154
				12	1.00000	100,000	1,051,828

(1) Expected length of eligibility based on adjusted existing caseload length of eligibility (see Existing Caseload, Exhibit 6): 10.5
Enrollment capped at 50,000 members in FFY 1996 and 100,000 members in years FFY 1997 - FFY 2000.

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APPENDIX 5.B

EXHIBIT 5

EXPANDED CASELOAD:
EXPECTED ENROLLMENT OF UNINSURED ADULT POPULATION
UNDER 100% FPL FOR WAIVER YEARS

	Uninsured Population Under 100% FPL	Expected Presentation Rate By End of Year	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members (1)	Cumulative Member Months (1)
Waiver Year 4: FFY 1999	119,402	90%	107,461	1	0.08333	100,000	87,652
Rate of enrollment based on				2	0.16667	100,000	175,305
annual population increase				3	0.25000	100,000	262,957
distributed equally over				4	0.33333	100,000	350,609
12 months.				5	0.41667	100,000	438,262
				6	0.50000	100,000	525,914
Statewide geographic				7	0.58333	100,000	613,566
coverage: 100.0%				8	0.66667	100,000	701,218
				9	0.75000	100,000	788,871
				10	0.83333	100,000	876,523
				11	0.91667	100,000	964,175
				12	1.00000	100,000	1,051,828
Waiver Year 5: FFY 2000	123,358	90%	111,022	1	0.08333	100,000	87,652
Rate of enrollment based on				2	0.16667	100,000	175,305
annual population increase				3	0.25000	100,000	262,957
distributed equally over				4	0.33333	100,000	350,609
12 months.				5	0.41667	100,000	438,262
				6	0.50000	100,000	525,914
Statewide geographic				7	0.58333	100,000	613,566
coverage: 100.0%				8	0.66667	100,000	701,218
				9	0.75000	100,000	788,871
				10	0.83333	100,000	876,523
				11	0.91667	100,000	964,175
				12	1.00000	100,000	1,051,828

(1) Expected length of eligibility based on adjusted existing caseload length of eligibility (see Existing Caseload, Exhibit 6): 10.5
Enrollment capped at 50,000 members in FFY 1996 and 100,000 members in years FFY 1997 - FFY 2000.

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APPENDIX 5.B

EXHIBIT 6

EXPANDED CASELOAD:
EXPECTED ENROLLMENT OF UNINSURED ADULT POPULATION
BETWEEN 100-200% FPL FOR WAIVER YEARS

	Uninsured Population Between 100-200% FPL	Expected Presentation Rate By End of Year	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members (1)	Cumulative Member Months (1)
Waiver Year 1: FFY 1996	0	0%	0	1		0	0
Rate of enrollment based on				2		0	0
Oregon experience.				3		0	0
(1st 3 months) 29.4%				4		0	0
				5		0	0
Missouri increase in				6		0	0
population.				7		0	0
				8		0	0
Geographic phase-in of				9		0	0
Northwest and St. Louis				10		0	0
regions: 59.8%				11		0	0
				12		0	0
Waiver Year 2: FFY 1997	142,453	50%	71,227	1	0.08971	6,390	6,390
Rate of enrollment based on				2	0.18747	13,353	19,743
Oregon experience.				3	0.29400	20,941	40,683
				4	0.35515	25,296	65,979
Missouri increase in				5	0.42003	29,918	95,897
population.				6	0.48889	34,822	130,719
				7	0.56195	40,026	170,744
Additional phase-in of				8	0.63948	45,548	216,292
Northeast, Central, Southwest,				9	0.72175	51,408	267,700
and Southeast regions: 100.0%				10	0.80905	57,626	325,327
				11	0.90169	64,225	389,551
				12	1.00000	71,227	460,778
Waiver Year 3: FFY 1998	147,173	60%	88,304	1	0.08971	72,759	70,016
Rate of enrollment based on				2	0.18747	74,428	141,638
Oregon experience.				3	0.29400	76,247	215,010
				4	0.35515	77,292	289,388
Missouri increase in				5	0.42003	78,400	364,832
population.				6	0.48889	79,576	441,407
				7	0.56195	80,823	519,183
Statewide geographic				8	0.63948	82,147	598,234
coverage: 100.0%				9	0.72175	83,552	678,636
				10	0.80905	85,043	760,473
				11	0.90169	86,625	843,832
				12	1.00000	88,304	928,807

(1) Expected length of eligibility based on adjusted existing caseload length of eligibility (see Existing Caseload, Exhibit 6): 10.5
Enrollment capped at 50,000 members in FFY 1996 and 100,000 members in years FFY 1997 - FFY 2000.

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APPENDIX 5.B

EXHIBIT 6

EXPANDED CASELOAD:
EXPECTED ENROLLMENT OF UNINSURED ADULT POPULATION
BETWEEN 100-200% FPL FOR WAIVER YEARS

	Uninsured Population Between 100-200% FPL	Expected Presentation Rate By End of Year	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members (1)	Cumulative Member Months (1)
Waiver Year 4: FFY 1999	152,050	70%	106,435	1	0.08333	89,815	81,409
Rate of enrollment based on				2	0.16667	91,326	164,188
annual population increase				3	0.25000	92,837	248,336
distributed equally over				4	0.33333	94,348	333,853
12 months.				5	0.41667	95,859	420,740
				6	0.50000	97,369	508,997
Statewide geographic				7	0.58333	98,880	598,623
coverage: 100.0%				8	0.66667	100,000	689,264
				9	0.75000	100,000	779,905
				10	0.83333	100,000	870,546
				11	0.91667	100,000	961,187
				12	1.00000	100,000	1,051,828
Waiver Year 5: FFY 2000	157,088	70%	109,961	1	0.08333	100,000	87,652
Rate of enrollment based on				2	0.16667	100,000	175,305
annual population increase				3	0.25000	100,000	262,957
distributed equally over				4	0.33333	100,000	350,609
12 months.				5	0.41667	100,000	438,262
				6	0.50000	100,000	525,914
Statewide geographic				7	0.58333	100,000	613,566
coverage: 100.0%				8	0.66667	100,000	701,218
				9	0.75000	100,000	788,871
				10	0.83333	100,000	876,523
				11	0.91667	100,000	964,175
				12	1.00000	100,000	1,051,828

(1) Expected length of eligibility based on adjusted existing caseload length of eligibility (see Existing Caseload, Exhibit 6): 10.5
Enrollment capped at 50,000 members in FFY 1997 and 100,000 members in years FFY 1998 - FFY 2000.

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APPENDIX 5.B

EXHIBIT 7

EXPANDED CASELOAD:
BASELINE EXPECTED ENROLLMENT OF UNINSURED 1902(r)(2)
POPULATON OF CHILDREN UNDER 200% FPL FOR WAIVER YEARS

	Children (under age 19) Under 200% FPL	Expected Presentation Rate By End of Year	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members	Cumulative Member Months (1)
Waiver Year 1: FFY 1996	114,912	70%	80,438	1	0.08971	7,216	6,569
Rate of enrollment based on				2	0.18747	15,080	20,298
Oregon experience.				3	0.29400	23,649	41,827
(1st 3 months) 29.4%				4	0.35515	28,567	67,834
				5	0.42003	33,787	98,592
Missouri increase in				6	0.48889	39,325	134,393
population.				7	0.56195	45,202	175,543
				8	0.63948	51,439	222,372
				9	0.72175	58,056	275,225
No Geographic Phase-in				10	0.80905	65,079	334,471
				11	0.90169	72,531	400,501
				12	1.00000	80,438	473,729
Waiver Year 2: FFY 1997	118,719	80%	94,975	1	0.08333	81,650	74,332
Rate of enrollment based on				2	0.16667	82,861	149,766
Oregon experience and				3	0.25000	84,072	226,303
increase in population.				4	0.33333	85,284	303,943
				5	0.41667	86,495	382,686
				6	0.50000	87,707	462,532
				7	0.58333	88,918	543,481
				8	0.66667	90,129	625,532
				9	0.75000	91,341	708,686
No Geographic Phase-in				10	0.83333	92,552	792,944
				11	0.91667	93,764	878,304
				12	1.00000	94,975	964,766
Waiver Year 3: FFY 1998	122,653	90%	110,387	1	0.08333	96,260	87,632
Rate of enrollment based on				2	0.16667	97,544	176,433
Oregon experience and				3	0.25000	98,828	266,404
increase in population.				4	0.33333	100,113	357,544
				5	0.41667	101,397	449,853
				6	0.50000	102,681	543,331
				7	0.58333	103,966	637,979
				8	0.66667	105,250	733,795
				9	0.75000	106,534	830,781
No Geographic Phase-in				10	0.83333	107,819	928,937
				11	0.91667	109,103	1,028,261
				12	1.00000	110,387	1,128,755

(1) Expected length of eligibility based on adjusted existing caseload length of eligibility (see Existing Caseload, Exhibit 6): 10.9

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APPENDIX 5.B

EXHIBIT 7

EXPANDED CASELOAD:
BASELINE EXPECTED ENROLLMENT OF UNINSURED 1902(r)(2)
POPULATON OF CHILDREN UNDER 200% FPL FOR WAIVER YEARS

	Children (under age 19) Under 200% FPL	Expected Presentation Rate By End of Year	Expected Enrollment By End Of Year	Month	Enrollment Rate for Phase-in of New Pop.	Monthly Members	Cumulative Member Months (1)
Waiver Year 4: FFY 1999	126,717	90%	114,045	1	0.08333	110,692	100,771
Rate of enrollment based on				2	0.16667	110,997	201,820
annual population increase				3	0.25000	111,302	303,146
distributed equally over				4	0.33333	111,606	404,749
12 months.				5	0.41667	111,911	506,630
				6	0.50000	112,216	608,789
				7	0.58333	112,521	711,225
				8	0.66667	112,826	813,938
				9	0.75000	113,130	916,929
No Geographic Phase-in				10	0.83333	113,435	1,020,198
				11	0.91667	113,740	1,123,744
				12	1.00000	114,045	1,227,567
Waiver Year 5: FFY 2000	130,915	90%	117,824	1	0.08333	114,360	104,110
Rate of enrollment based on				2	0.16667	114,675	208,507
annual population increase				3	0.25000	114,990	313,190
distributed equally over				4	0.33333	115,304	418,160
12 months.				5	0.41667	115,619	523,417
				6	0.50000	115,934	628,960
				7	0.58333	116,249	734,790
				8	0.66667	116,564	840,907
No Geographic Phase-in				9	0.75000	116,879	947,311
				10	0.83333	117,194	1,054,001
				11	0.91667	117,509	1,160,977
				12	1.00000	117,824	1,268,241

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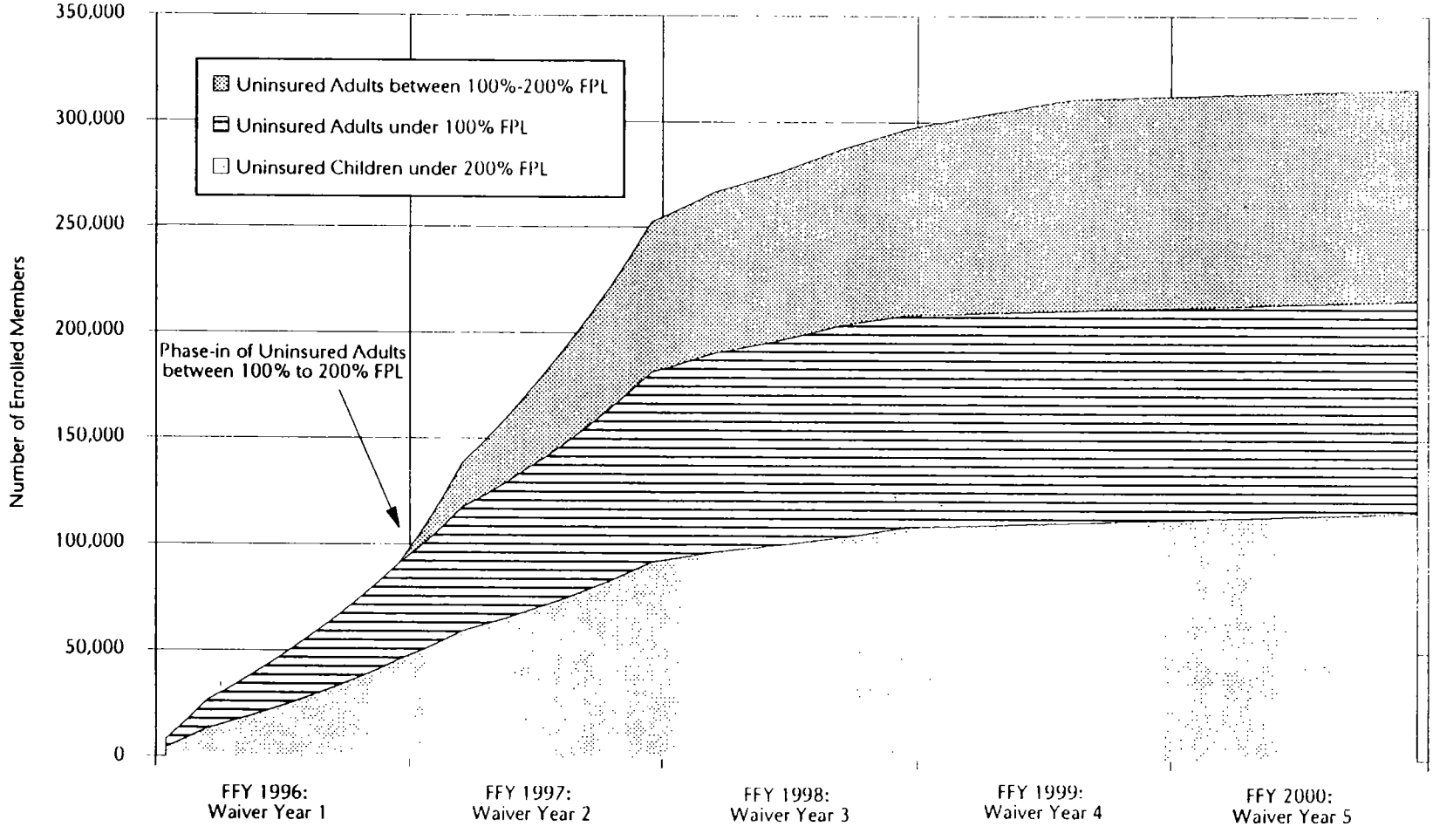
APPENDIX 5.B

EXHIBIT 8

EXPANDED CASELOAD:
ENROLLMENT OF UNINSURED INTO WAIVER PROGRAM



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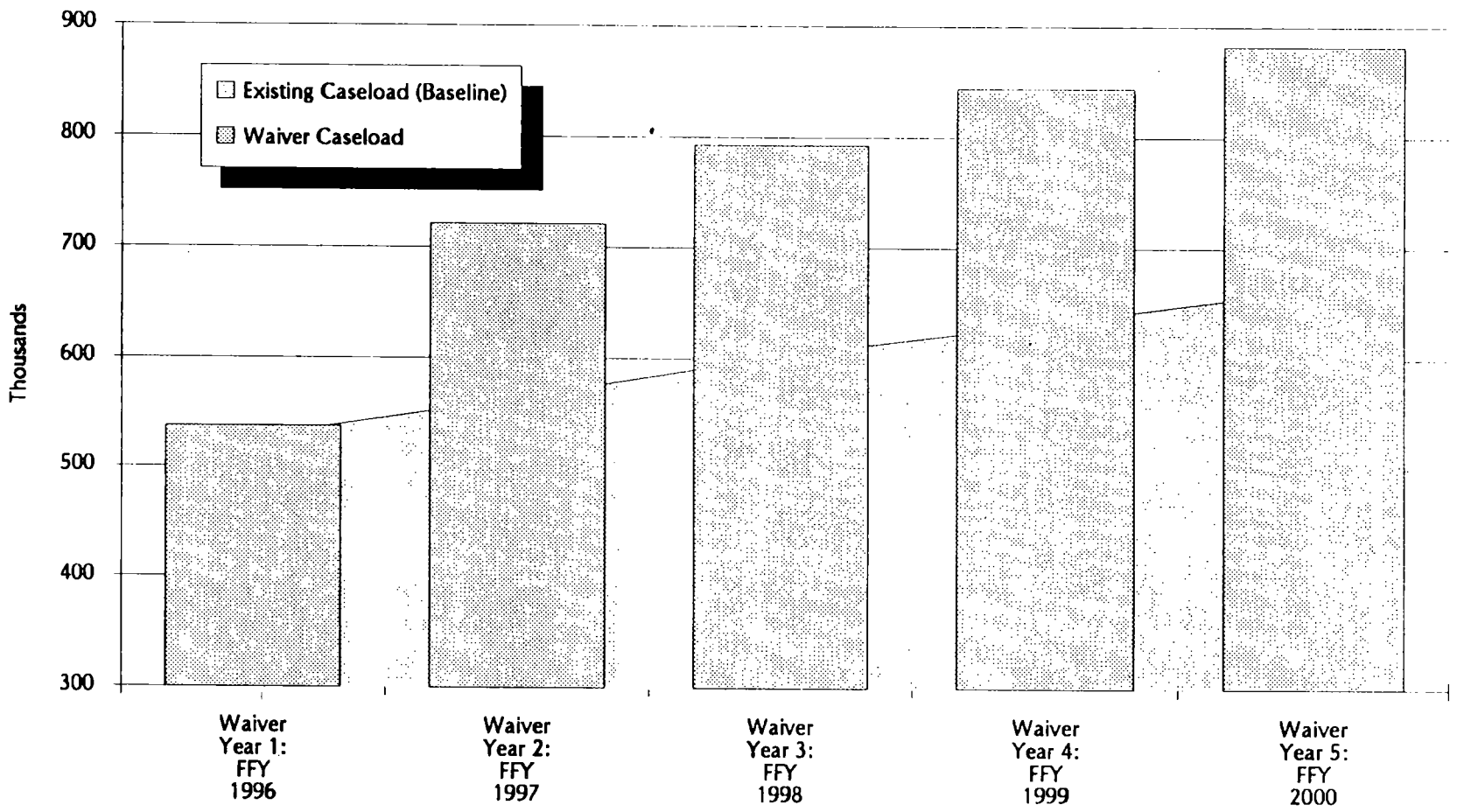
APPENDIX 5.B

EXHIBIT 9

EXPANDED PROGRAM:
NUMBER OF WAIVER ENROLLEES VERSUS BASELINE PROGRAM



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APPENDIX 5.B

EXHIBIT 10

EXPANDED CASELOAD:
UNINSURED TARGET POPULATION
NUMBER OF MEMBER MONTHS

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Number of Member Months for Children (Under 21 years of age) Under 200% FPL	295,068	847,237	1,187,245	1,226,582	1,267,224
Number of Member Months for Uninsured Adults under 100% FPL	293,413	829,796	1,051,828	1,051,828	1,051,828
Number of Member Months for Uninsured Adults between 100% to 200% FPL	0 (1)	460,778	928,807	1,051,828	1,051,828
Number of Member Months for Total Expanded Waiver	588,480	2,137,812	3,167,879	3,330,238	3,370,879

(1) Phase-in of coverage for Adults between 100-200% FPL occurs in Year 2: FFY 1997 of the Waiver. Population enters program at the same presentation rate as the other populations that entered program in Year 1 of the waiver.

5-C. CALCULATION OF PER MEMBER PER MONTH (PMPM) COST

OVERVIEW OF ESTIMATION PROCESS FOR PER MEMBER PER MONTH (PMPM) COSTS

EXHIBIT 1: EXISTING MEDICAID PROGRAM PAYMENTS

EXHIBIT 2: EXISTING MEDICAID PROGRAM PAYMENTS: COST PER MEMBER PER MONTH (PMPM)

EXHIBIT 3: AVERAGE PER MEMBER PER MONTH WAIVER YEARS COST ESTIMATES

EXHIBIT 4: PER MEMBER PER MONTH ADVERSE RISK SELECTION ADJUSTMENT

EXHIBIT 5: DISABLED VOLUNTARY MANAGED PILOT PROGRAM: PER MEMBER PER MONTH (PMPM) AND TOTAL COST ESTIMATES

OVERVIEW OF ESTIMATION PROCESS FOR PER MEMBER PER MONTH (PMPM) COSTS

The per member per month (PMPM) costs for the Waiver program (for both the existing and expanded eligibility groups) are derived from historical program data and projections about future growth and are considered proxies for estimating managed care expenditures.

Step 1: Calculate PMPM Costs Based on Historical Experience of the Missouri Medicaid Program. Missouri Medicaid program expenditure data for the each of the seven eligibility categories (Aged (Pharmacy Only), AFDC, Disabled (Pharmacy Only), Medicaid for Pregnant Women, Medicaid for Children, Other FFP, and Other State) for SFYs 1990 - 1994 serve as the basis for the PMPM cost calculations. The Aged and Disabled eligibility groups are displayed and will be included in the PMPM costs for the pharmacy managed network cost calculations only. Exhibit 1 displays the total program payments for the seven eligibility categories over the state fiscal years.

The PMPM costs are computed by dividing the existing population member months into the payment amounts for the eligibility categories. Exhibit 2 displays the PMPM costs for SFY 1990 - SFY 1994.

Step 2: "Grow" Base Year Estimates from 1994 to End of Waiver. To determine the PMPM costs throughout the waiver years, it is necessary to apply inflation factors to base year payments and to make some minor cost adjustments. This is accomplished in the following manner:

(a) First, SFY 1994 PMPM payments are inflated to the midpoint of the first year of the waiver, FFY 1996, by applying the average increase in PMPM payments between SFY 1993 and SFY 1994.

(b) Next, an additional $1 is added to the PMPM cost to reflect the transportation cost PMPM add-on to the AFDC, Medicaid for Pregnant Women, Medicaid for Children, Other FFP, and Other State eligibility groups.

(c) The waiver year FFY 1996 PMPM cost is then inflated throughout the waiver years using the Medical Consumer Price Index. It should be noted that the inpatient disproportionate share payments that are included in the FFY 1996 PMPM costs are not inflated; therefore, this dollar amount was removed, the remaining PMPM costs were inflated, and then the inpatient disproportionate share payments were added back into the costs. Exhibit 3 displays the PMPM costs throughout the waiver years.

Step 3: Calculate PMPM Adverse Risk Selection Adjustment. It is expected that the premium cost sharing requirement for both uninsured adults and children between 100 and 200% FPL will result in the enrollment of a higher portion of eligibles in need of medical care than would occur if no premium cost sharing requirement existed. Therefore, an adjustment was necessary to reflect this expected "adverse selection". Using HCFA-2082 data for the State of Missouri, the percentage difference between the cost per recipient and the cost per eligible was calculated for AFDC Adults and AFDC Children under 21. The gross percentages for each eligibility group was adjusted downward by 5% to reflect the expectation that the higher socioeconomic status of the population between 100% and 200% FPL relative to that of the existing Medicaid population would result in a slightly better overall health status and thus slightly lower cost. Exhibit 4 displays the components and results of these calculations.

Step 4: Estimate Per Member Per Month and Total Costs for the Disabled Pilot Program. The cost of implementing the voluntary pilot program for the existing disabled population is separately estimated throughout the waiver years. Cost per member per month is derived through the steps described above, and total costs are calculated by multiplying the disabled PMPM costs by the expected enrollment in the program (for the calculation of caseload, see the Existing Caseload Appendix, Exhibit 8). Exhibit 5 displays the results of these calculations.

APPENDIX 5.C

EXHIBIT 1

EXISTING MEDICAID PROGRAM PAYMENTS

Total Adjusted Payment Amounts (1)

	SFY 1990 PAYMENTS	SFY 1991 PAYMENTS	SFY 1992 PAYMENTS	SFY 1993 PAYMENTS	SFY 1994 PAYMENTS
Aged (Pharmacy Only)	$28,871,033	$38,198,952	$57,827,642	$68,784,682	$87,209,835
AFDC	$204,487,480	$234,311,801	$282,865,502	$323,866,483	$393,000,298
Disabled (Pharmacy Only)	$29,356,725	$35,258,000	$53,438,780	$73,241,920	$86,992,662
Medicaid Pregnant Women (MPW)	$22,135,210	$35,564,740	$50,681,889	$65,357,661	$60,488,007
Medicaid for Children (MFC)	$15,133,638	$27,632,289	$44,406,369	$63,299,437	$61,192,075
Other FFP	$25,578,995	$36,397,411	$49,271,750	$58,894,635	$68,035,024
Other State	$19,354,464	$19,420,202	$16,442,552	$17,890,791	$28,142,314
Totals (3)	$286,689,788	$353,326,443	$443,668,062	$529,309,007	$610,857,719

Percentage Change (2)

	SFY 1990 PAYMENTS	SFY 1991 PAYMENTS	SFY 1992 PAYMENTS	SFY 1993 PAYMENTS	SFY 1994 PAYMENTS
Aged (Pharmacy Only)		32.3%	51.4%	18.9%	26.8%
AFDC		14.6%	20.7%	14.5%	21.3%
Disabled (Pharmacy Only)		20.1%	51.6%	37.1%	18.8%
Medicaid Pregnant Women (MPW)		60.7%	42.5%	29.0%	-7.5%
Medicaid for Children (MFC)		82.6%	60.7%	42.5%	-3.3%
Other FFP		42.3%	35.4%	19.5%	15.5%
Other State		0.3%	-15.3%	8.8%	57.3%
Totals (3)		23.2%	25.6%	19.3%	15.4%

(1) Payment amount reflect the following adjustments and exclusions:

(a) Includes 3rd Party Liability Payments.

(b) Includes inpatient disproportionate share dollars (except Aged and Disabled), all other disproportionate share is excluded.

(c) Dental service dollars for adults are excluded (outside of waiver).

(2) Reflects both changes in payments and people covered by the existing program.

(3) Totals exclude Aged (Pharmacy Only) and Disabled (Pharmacy Only) eligibility categories.

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APPENDIX 5.C

EXHIBIT 2

EXISTING MEDICAID PROGRAM PAYMENTS:
COST PER MEMBER PER MONTH (PMPM)

Per Member Per Month Costs (1)

	SFY 1990 PMPM	SFY 1991 PMPM	SFY 1992 PMPM	SFY 1993 PMPM	SFY 1994 PMPM
Aged (Pharmacy Only)	$48.82	$54.33	$81.69	$97.19	$113.49
AFDC	$82.05	$85.90	$91.11	$99.85	$119.72
Disabled (Pharmacy Only)	$43.30	$52.33	$75.45	$90.09	$97.97
Medicaid Pregnant Women (MPW)	$499.62	$495.36	$540.92	$605.63	$553.49
Medicaid for Children (MFC)	$100.56	$81.64	$73.72	$72.92	$53.94
Other FFP	$329.10	$304.10	$307.68	$358.48	$389.31
Other State	$194.96	$219.29	$202.96	$201.09	$298.11
Totals (2)	$100.10	$105.58	$109.76	$118.34	$127.38

Percentage Change from Previous Year

	SFY 1990 PMPM	SFY 1991 PMPM	SFY 1992 PMPM	SFY 1993 PMPM	SFY 1994 PMPM
Aged (Pharmacy Only)		11.3%	50.4%	19.0%	16.8%
AFDC		4.7%	6.1%	9.6%	19.9%
Disabled (Pharmacy Only)		20.8%	44.2%	19.4%	8.7%
Medicaid Pregnant Women (MPW)		-0.9%	9.2%	12.0%	-8.6%
Medicaid for Children (MFC)		-18.8%	-9.7%	-1.1%	-26.0%
Other FFP		-7.6%	1.2%	16.5%	8.6%
Other State		12.5%	-7.4%	-0.9%	48.2%
Totals (2)		5.5%	4.0%	7.8%	7.6%

(1) Per Member Month Costs consist of the following: Existing Medicaid Program Payments (Adjusted, see Exhibit 1)) divided by Total Member Months, where Member Months equal:
Average Number of Monthly Eligibles (see Existing Caseload Appendix, Exhibit 1) multiplied by Full Year Equivalent Length of Eligibility (see Existing Caseload Appendix, Exhibit 7).

(2) Totals do not include pharmacy only costs for the Aged and Disabled categories.

APPENDIX 5.C

EXHIBIT 3

AVERAGE PER MEMBER PER MONTH WAIVER YEARS COST ESTIMATES (1), (2), (3)

	SFY 1994 Payments	SFY 1994 Member Months (4)	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Aged (Pharmacy Only)	$87,209,835	768,408	$136.27	$144.03	$152.24	$160.92	$170.09
AFDC	$393,000,298	3,282,552	$142.00	$149.32	$157.05	$165.22	$173.86
Disabled (Pharmacy Only)	$86,992,662	887,916	$117.63	$124.34	$131.42	$138.92	$146.83
Medicaid Pregnant Women (MPW)	$60,488,007	109,284	$647.51	$679.29	$712.88	$748.39	$785.93
Medicaid for Children (MFC)	$61,192,075	1,134,480	$64.53	$67.86	$71.38	$75.10	$79.03
Other FFP	$68,035,024	174,756	$457.24	$480.12	$504.30	$529.87	$556.89
Other State	$28,142,314	94,404	$351.93	$370.01	$389.11	$409.31	$430.65
Totals (5)	$610,857,719	4,795,476	$150.82	$158.53	$166.67	$175.29	$184.39

(1) Includes $1 PMPM transportation cost add-on (excluding Aged and Disabled).

(2) It was assumed that between the base year (SFY 1994) and the first year of the waiver (FFY 1996) that the PMPM costs would increase at the same rate as the average program costs have increased between SFY 1993 and SFY 1994: 8.5%

(3) After the first year of the program it was assumed that PMPM costs would increase at the same rate as the Medical Consumer Price Index (CPI) for the remaining four years of the waiver: 5.7%

(4) The calculation of existing caseload numbers is computed by multiplying the SFY 1994 Average Number of Monthly Members (Existing Caseload Appendix, Exhibit 5) by 12 months.

(5) Totals exclude pharmacy only costs for the Aged and Disabled population categories.

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APPENDIX 5.C

EXHIBIT 4

PER MEMBER PER MONTH ADVERSE RISK SELECTION ADJUSTMENT

	Total Medicaid Payments	Recipients	Eligibiles	Total Eligibiles	Payment Per Recipients	Payment per Eligible	Gross Adjustment Percentage	Modified Adjustment Percentage (minus 5%) (2)
AFDC Children under 21	$234,272,440	258,573	200,331	324,322	$906.02	$722.35	25.43%	20.43%
AFDC Adults	$175,329,449	137,413	101,736	159,209	$1,275.93	$1,101.25	15.86%	10.86%

(1) Source: HCFA-2082, State of Missouri, FFY 1992.

(2) A downward adjustment of 5% is made to reflect the better overall health status of the expanded population over that of the existing Medicaid population. The adverse risk selection adjustment is only applied to populations between 100-200% FPL.

APPENDIX 5.C

EXHIBIT 5

DISABLED VOLUNTARY MANAGED PILOT PROGRAM:
PER MEMBER PER MONTH (PMPM) AND TOTAL COST ESTIMATES

PER MEMBER PER MONTH COSTS (with SecureCare)

	SFY 1994 Payments	SFY 1994 Member Months	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Disabled (1), (2), (3)	$322,733,735	887,916	$429.81	$452.16	$475.77	$500.74	$527.12
Disabled (Pharmacy Only), (2), (3)	$86,992,662	887,916	$117.63	$124.34	$131.42	$138.92	$146.83
Disabled excluding Pharmacy	$235,741,073	887,916	$312.18	$327.82	$344.35	$361.82	$380.29

ESTIMATED POPULATION

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Projected Eligibles	1,090	1,393	1,731	2,106	2,384
Target Population Member Months	7,051	15,038	18,899	23,210	26,402

ESTIMATED PROGRAM COSTS

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Baseline Disabled Costs (excl. Pharmacy) (3), (4)	$3,023,352	$6,946,474	$9,408,425	$12,458,331	$15,286,962
Enrolled Eligible Costs with Waiver	$2,201,038	$4,929,881	$6,507,928	$8,397,857	$10,040,368
Costs under Managed Care	$2,090,986	$4,560,140	$6,019,833	$7,768,018	$9,287,340

(1) Includes $1 PMPM transportation cost add-on (excluding Aged and Disabled).

(2) It was assumed that between the base year (SFY 1994) and the first year of the waiver (FFY 1996) that the PMPM costs would increase at the same rate as the average program costs have increased between SFY 1993 and SFY 1994: 8.5%

(3) After the first year of the program it was assumed that PMPM costs would increase at the same rate as the Medical Consumer Price Index (CPI) for the remaining four years of the waiver: 5.7%

(4) PMPM cost inflation per annum during waiver years is the program inflation from SFY 1993 to SFY 1994: 8.5%

5-D. TABLE OF CONTENTS
WAIVER PROGRAM ESTIMATES

OVERVIEW OF THE PROCESS FOR ESTIMATING WAIVER PROGRAM COSTS

Once the existing and expanded caseloads are determined and the "rate component" (per member per month (PMPM) costs) are computed, the total costs of the waiver program can be estimated. Several steps are necessary to complete this estimation process and may be grouped into four broad categories:

- Total Baseline Medicaid Program Costs
- Total Medicaid Program Costs Under the Waiver

- Financial Impact of Premium Cost Sharing Requirement
- Financial Impact of Waiver Program on Total Program Costs

The remainder of this appendix overview is divided into sections corresponding to these four categories.

TOTAL BASELINE MEDICAID PROGRAM COSTS

In order to evaluate the financial impact of the Waiver, it is first necessary to project what program costs are expected to be in the absence of the waiver program. The without waiver projection is the financial baseline against which the Waiver program is measured. The source for the majority of the components of the without waiver baseline is the State's budget projections and therefore it is not necessary to provide an overview of various individual estimation steps. Four individual components of the budget are included in this baseline taken from the State's budget:

a) Existing Baseline Program Service Costs. This represents service costs for the population covered under Missouri's existing Medicaid eligibility criteria and benefits package.

(b) Disproportionate Share Payments. This estimate includes inpatient hospital and mental health facility disproportionate share payments. Disproportionate share has been capped throughout the waiver years as a result of Missouri's "high" disproportionate share status.

(c) Section 1902 (r)(2) Expanded Program Costs — Children under 200% FPL. Without the implementation of the Waiver, the State anticipates addressing its goal to expand coverage by implementing 1902(r)(2) allowable coverage increases for children (under age 19) under 200% FPL. This component of the baseline estimate was taken from existing State budget estimates of the current Medicaid for Children program. These costs differ from the Waiver program estimates for this population because it includes the cost of services that were not included in the Waiver basic benefits package. The following assumptions have been made:

- Inpatient disproportionate share dollars have been included in cost estimates.

- Caseload is expected to reflect increases in length of eligibility that is projected to occur as a result of the expanded income eligibility for this population.

(d) Determine Administrative Costs. Administrative costs are projected over the waiver years based on current program administrative costs.

Total baseline costs are calculated for each year by summing (a) - (d) above for each year of the waiver. Federal Financial Participation (FFP) is calculated based on 59.85% for all services, except for family planning services which are matched at 90%. State-only medical program dollars are included in this estimate but receive no federal match.

TOTAL MEDICAID PROGRAM COSTS UNDER THE WAIVER

The process used to estimate expenditures under the Waiver is based on the caseload and cost calculations described in Appendices 5.A - 5.C. Described below are the steps performed to estimate the cost of the Medicaid program with the implementation of the waiver:

Step 1: Calculate Existing Program Costs Excluding the FFS Cost of the Existing Caseload to be Included in the Waiver. The first step is to isolate those baseline costs not affected by the Waiver from those baseline costs that will change as a result of the Waiver. This is accomplished by taking the Existing Program Baseline Costs described above and excluding the fee-for-service (FFS) cost of the existing caseload and services that will be included under the waiver (including Pharmacy Program Costs for the Aged and Disabled). The "the Waiver comparable" caseload and service costs are projected using existing caseload member months and the FFS PMPM costs specific to each of the seven eligibility categories covered under the waiver and the disabled pilot program.

Exhibit 1 displays the caseload for all populations to be included under the waiver program and Exhibit 2 displays the baseline FFS cost of the existing caseload and the cost of the existing program under the waiver.

Step 2: Determine Special Payments for Essential Services (SPES). This amount represents the estimated payments for services provided to that portion of the Waiver's target population that is not enrolled in capitated health plan.

Step 3: Estimate Total Waiver Program Costs, Existing and Expanded Programs (Includes Pharmacy Program). This represents the costs the State expects to be incurred for the caseload and services included within the Waiver. Costs reflect geographic phase-in, increases in length of eligibility, and inpatient SPES.

Estimates of costs are calculated for the existing program, the pharmacy managed network for the aged and disabled groups, and for the three expanded population groups to be covered under the waiver: children under 200% FPL, uninsured adults under 100% FPL, and uninsured adults between 100% and 200% FPL. For each of the waiver years, costs are estimated by multiplying the appropriate PMPM cost by the corresponding number of member months.

The PMPM cost values from the existing program PMPM calculations are used as proxies for the expanded program. For the children under 200% FPL category, the Medicaid for Children (MFC) PMPM cost is used to estimate the cost of this expanded group. The existing program AFDC PMPM cost is used to estimate the cost of covering both uninsured adults under 100% and uninsured adults between 100% and 200% FPL categories. For the groups included within the pharmacy managed network, the aged and disabled pharmacy PMPM costs are used.

Because of the geographic phase-in of the managed care program over the first two years of the waiver, the costs of services for the existing caseload under managed care are assumed to be lower than the costs for eligibles outside of the geographic service areas that are paid fee-for-service. As a result, managed care savings are only computed on services under managed care. The savings associated with the existing eligibility groups included under the waiver are assumed to save 5% in the first year of the waiver and 7.5% in all subsequent waiver years. The pharmacy managed network will be phased-in statewide and is expected to save 10% in the first year of

the waiver and 12.5% in each of the subsequent waiver years. Exhibit 2 displays the estimates of costs and managed care savings for the existing program under the Waiver.

The calculation of total costs for the expanded caseload is similar to that of the existing caseload except that services outside of the geographic service areas are excluded entirely from the waiver program until they are phased-in under the waiver. Therefore, managed care savings are only based on costs within service areas, which are assumed to be 5% in FFY 1996 and 7.5% in all subsequent waiver years, FFY 1997 - FFY 2000. Exhibit 3 displays the costs of the expanded caseload under the Waiver.

Step 4: Estimate Disabled Pilot Program Costs. The estimate of the costs for this program are included in Appendix C, Calculation of Per Member Per Month (PMPM) Cost, Exhibit 5. This voluntary program covers the existing disabled population and is assumed to result in managed care savings of 5% in FFY 1996, and 7.5% in all subsequent waiver years.

Step 5: Determine Administrative Costs. Administrative costs are projected over the waiver years for both the existing program and the expanded program under the Waiver.

Step 6: Estimate Total Program Costs. Total costs are calculated for each year by summing the results of Step 1 - 5 above.

Step 7: Determine Federal Financial Participation (FFP). This amount is projected in the same manner as the baseline FFP with one exception. The populations and benefits covered by some state-only medical programs are contained within the coverage of the Waiver and these formerly state-only expenditures now receive FFP.

FINANCIAL IMPACT OF PREMIUM COST SHARING REQUIREMENT

The State assumes financial liability for the premium cost share requirement of the expanded population between 100% and 200% FPL. However, substantial analysis was performed to evaluate the financial impact to enrollees of the premium cost share requirements.

Step 1: The total premium cost sharing dollar amounts were calculated individually for children and adults and are shown on Exhibit 4. This table projects the aggregate impact of the premium cost sharing requirement.

Step 2: Examples of how the premium cost sharing requirement would apply to specific family sizes were also evaluated and these results are shown on Exhibit 5.

Step 3: Because a transaction cost of $7.50 per family (assuming an average family size of 3.4) is associated with the collection of the premiums, total aggregate premium cost sharing dollars shown in Exhibit 4 were recalculated assuming that the premium cost would also include the transaction cost (see Exhibit 6).

Step 4: The impact of the premium cost sharing requirement was also evaluated graphically, both as a share of per month premiums as income increases and premium cost sharing as a percent of income for a family of 4 (Exhibit 7 and 8).

FINANCIAL IMPACT OF WAIVER PROGRAM ON TOTAL PROGRAM COSTS

The final component of the analysis is the comparison between the overall cost of the program without and with the implementation of the Waiver. Exhibit 9 presents the cost of the expanded population under the Waiver, and Exhibit 10 summarizes this information as well as the cost of the existing population under the Waiver (Exhibit 2 of this appendix) and presents the overall financial impact of the waiver.

Step 1: Calculate Total Program Savings/Additional Costs. This represents the difference between the total Medicaid program costs without the waiver and total Medicaid program costs with the waiver.

Step 2: Determine Federal FFP Savings/Additional Costs. This represents the savings that the federal government would realize for each waiver year. It is computed by calculating the difference in FFP for the baseline Medicaid program and the waiver program.

APPENDIX 5.D

EXHIBIT 1

WAIVER PROGRAM:
TOTAL WAIVER POPULATION AND MEMBER MONTHS (1)

Number of Members

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Existing Population	446,787	468,756	492,454	518,051	545,738
Existing Population w/Geographic Phase-in (2)	*258,511*	*468,756*	*492,454*	*518,051*	*545,738*
Children (Under 21 years of age) Under 200% FPL	45,611	91,970	108,677	112,278	115,999
Uninsured Adults under 100% FPL	45,355	89,493	104,015	107,461	111,022
Uninsured Adults between 100% to 200% FPL	0	71,227	88,304	106,435	109,961
Total Population with Geographic Phase-in (2)	349,478	721,445	793,450	844,226	882,720

Number of Member Months

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Existing Population	6,196,372	6,494,128	6,815,031	7,161,364	7,535,653
Existing Population w/Geographic Phase-in (2)	*3,585,221*	*6,494,128*	*6,815,031*	*7,161,364*	*7,535,653*
Children (Under 21 years of age) Under 200% FPL	295,068	847,237	1,187,245	1,226,582	1,267,224
Uninsured Adults under 100% FPL	45,355	89,493	100,000	100,000	100,000
Uninsured Adults between 100% to 200% FPL	0	460,778	928,807	1,051,828	1,051,828
Total Population with Geographic Phase-in (2)	3,925,644	7,891,636	9,031,082	9,539,774	9,954,704

(1) All values for the expanded population are calculated based on varying presentation rates, enrollment rates, and expected length of eligibility, over the waiver years. See Expanded Caseload Appendix, Exhibits 4, 5, 6, and 7.

(2) Existing populations with and without geographic phase-in are shown because the financial impact of the program with and without the waiver will be evaluated, where a phase-in is required under managed care (i.e., with SecureCare) but not under the existing fee-for-service system (i.e., Baseline estimate). For the phase-in regions and the associated percent enrollment, see the Existing Caseload Appendix, Exhibit 5 and 7. Only the "Existing Population with Geographic Phase-in" is included in Total Population values.

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APPENDIX 5.D

EXHIBIT 2

WAIVER PROGRAM:
PROGRAM COST ESTIMATES FOR EXISTING PROGRAM (1)

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Pharmacy Related Costs (Aged and Disabled Only)					
Aged	$120,825,397	$135,375,191	$151,677,071	$169,942,024	$190,406,443
Disabled	$121,232,231	$136,471,728	$153,626,907	$172,938,577	$194,677,821
Total Waiver Program Pharmacy Costs	$242,057,628	$271,846,919	$305,303,978	$342,880,602	$385,084,264
Costs Assuming Managed Care Savings (2)	*$217,851,865*	*$237,866,054*	*$267,140,981*	*$300,020,527*	*$336,948,731*
Existing Program Eligibility Categories included in Waiver					
AFDC	$575,910,816	$620,717,928	$669,182,117	$721,606,452	$778,319,231
Medicaid Pregnant Women (MPW)	$132,395,527	$139,523,809	$147,087,790	$155,114,370	$163,632,115
Medicaid for Children (MFC)	$102,757,743	$119,976,848	$140,116,708	$163,676,789	$191,242,423
Other FFP	$99,436,487	$109,091,531	$119,721,835	$131,427,730	$144,319,952
Other State	$44,512,311	$50,526,180	$57,367,585	$65,151,652	$74,009,621
Existing Program Costs under Waiver	$955,012,884	$1,039,836,296	$1,133,476,036	$1,236,976,993	$1,351,523,342
Waiver Program Costs for Services under Managed Care (3)	*$524,941,932*	*$961,848,574*	*$1,048,465,333*	*$1,144,203,718*	*$1,250,159,091*
Waiver Program Costs for Services under Fee-for-Service (4), (5)	*$400,931,617*	*$0*	*$0*	*$0*	*$0*
Total Waiver Program Costs	*$925,873,549*	*$961,848,574*	*$1,048,465,333*	*$1,144,203,718*	*$1,250,159,091*
Total Costs for Existing Program under Waiver					
Waiver Program Costs for Services under Managed Care	*$1,143,725,414*	*$1,199,714,628*	*$1,315,606,314*	*$1,444,224,245*	*$1,587,107,823*

(1) Waiver program costs are computed for each eligibility category by multiplying PMPM cost (see PMPM Cost Appendix, Exhibit 7) by the existing caseload total member months (see Existing Caseload Appendix, Exhibit 6). All costs include inpatient disproportionate share costs.

(2) Managed care savings are assumed to be 10% in FFY 1996 and 12.5% in all subsequent waiver years, FFY 1997 - FFY 2000.

(3) Represents costs for those eligibles included in phase-in regions. Managed care savings are assumed to be 5% in FFY 1996 and 7.5% in all subsequent Waiver years, FFY 1997 - FFY 2000.

(4) Represents costs for those eligibles that are outside of regions included in geographic phase-in.

(5) Phase-in of population occurs in waiver years 1-2:

FFY 1996, NW and St. Louis	57.9%
FFY 1997, NE, Central, SW, and SE	42.1%

APPENDIX 5.D

EXHIBIT 3

EXPANDED PROGRAM:
COST ESTIMATES FOR EXPANDED PROGRAM BEFORE PREMIUM COST SHARING (1), (2), (3)

Children (Under 21 years of age) Under 200% FPL

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Expanded Caseload Member Months	295,068	847,237	1,187,245	1,226,582	1,267,224
Per Member Per Month (PMPM), (4)	$70.83	$74.49	$78.35	$82.43	$86.75
Per Member Per Month (PMPM) w/Managed Care	$67.29	$68.90	$72.47	$76.25	$80.24
Costs Assuming Managed Care Savings	**$19,855,022**	**$58,373,905**	**$86,041,952**	**$93,525,005**	**$101,682,261**

Uninsured Adults under 100% FPL

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Expanded Caseload Member Months	293,413	829,796	1,051,828	1,051,828	1,051,828
Per Member Per Month (PMPM)	$142.00	$149.32	$157.05	$165.22	$173.86
Per Member Per Month (PMPM) w/Managed Care	$134.90	$138.12	$145.27	$152.83	$160.82
Costs Assuming Managed Care Savings	**$39,582,457**	**$114,611,608**	**$152,801,618**	**$160,753,400**	**$169,158,434**

(continued)

(1) Large increase in Expanded Caseload Member Months between the first and second years of the waiver is the result of the geographic phase-in and the low enrollment in the early months of the waiver program.

(2) Expanded caseload represents only those eligibles that have enrolled under the geographically phased-in managed care program. All other eligibles outside the geographic cachement areas are not included in waiver program.

(3) Managed care savings are assumed to be 5% in FFY 1996 and 7.5% in all subsequent waiver years, FFY 1997 - FFY 2000.

(4) Reflects adverse risk selection adjustment for enrolled children between 100-200% FPL (see PMPM Appendix, Exhibit 4).

APPENDIX 5.D

EXHIBIT 3

EXPANDED PROGRAM:
COST ESTIMATES FOR EXPANDED PROGRAM BEFORE PREMIUM COST SHARING (1), (2), (3)

Uninsured Adults between 100% to 200% FPL

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Expanded Caseload Member Months	0	460,778	928,807	1,051,828	1,051,828
Per Member Per Month (PMPM), (4)	$157.43	$165.54	$174.11	$183.17	$192.75
Per Member Per Month (PMPM) w/Managed Care	$149.56	$153.12	$161.05	$169.43	$178.29
Costs Assuming Managed Care Savings	**$0**	**$70,555,442**	**$149,585,701**	**$178,213,908**	**$187,531,869**

Total Expanded Waiver Program

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Expanded Caseload Member Months	588,480	2,137,812	3,167,879	3,330,238	3,370,879
Per Member Per Month (PMPM Wgtd.) (5)	$101.00	$113.92	$122.61	$129.87	$135.98
Costs Assuming Managed Care Savings	**$59,437,479**	**$243,540,955**	**$388,429,271**	**$432,492,312**	**$458,372,563**

(1) Large increase in Expanded Caseload Member Months between the first and second years of the waiver is the result of the geographic phase-in and the low enrollment in the early months of the waiver program.

(2) Expanded caseload represents only those eligibles that have enrolled under the geographically phased-in managed care program. All other eligibles outside the geographic cachement areas are not included in waiver program.

(3) Managed care savings are assumed to be 5% in FFY 1996 and 7.5% in all subsequent waiver years, FFY 1997 - FFY 2000.

(4) Reflects adverse risk selection adjustment (see PMPM Appendix, Exhibit 4).

(5) PMPM is weighted by the Expanded Caseload Member months for each of the expanded populations.

APPENDIX 5.D

EXHIBIT 4

EXPANDED PROGRAM:
CALCULATION OF TOTAL PREMIUM COST SHARING FOR EXPANDED POPULATIONS;
PROGRESSIVE PREMIUM SHARING FOR CHILDREN UNDER 200% FPL AND ADULTS BETWEEN 100-200% FPL

Children (Under 21 years of age) Under 200% FPL

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Per Member Per Month (PMPM)	$70.83	$74.49	$78.35	$82.43	$86.75
(PMPM) assuming Managed Care Savings (1)	$67.29	$68.90	$72.47	$76.25	$80.24
Yearly Premium Equivalent	$807	$827	$870	$915	$963

Poverty Level	Percent of Eligible Enrollment (2)	Percent of Premium	Total Eligible Premium Obligation Costs (3)				
			Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
under 100%	52.2%	0.0%	$0	$0	$0	$0	$0
100-<110%	4.8%	7.5%	$72,213	$212,307	$312,937	$340,153	$369,821
110-<120%	4.8%	15.0%	$144,426	$424,615	$625,874	$680,306	$739,642
120-<130%	4.8%	22.5%	$216,640	$636,922	$938,810	$1,020,459	$1,109,463
130-<140%	4.8%	30.0%	$288,853	$849,230	$1,251,747	$1,360,611	$1,479,284
140-<150%	4.8%	37.5%	$361,066	$1,061,537	$1,564,684	$1,700,764	$1,849,105
150-<160%	4.7%	45.0%	$420,616	$1,236,614	$1,822,744	$1,981,267	$2,154,074
160-<170%	4.7%	52.5%	$490,719	$1,442,716	$2,126,534	$2,311,479	$2,513,086
170-<180%	4.7%	60.0%	$560,821	$1,648,819	$2,430,325	$2,641,690	$2,872,098
180-<190%	4.7%	67.5%	$630,924	$1,854,921	$2,734,116	$2,971,901	$3,231,111
190-<200%	4.7%	75.0%	$701,027	$2,061,023	$3,037,906	$3,302,112	$3,590,123
Totals	100%		$3,887,305	$11,428,704	$16,845,677	$18,310,743	$19,907,807

(1) Managed care savings are assumed to be 5% in FFY 1996 and 7.5% in all subsequent Waiver years, FFY 1997 - FFY 2000.

(2) See Expanded Caseload Appendix, Exhibit 2, for the number of eligibles within each poverty level.

(3) The premium cost sharing for each of the waiver years equals the product of the following:
Percent of Eligible Enrollment, Percent of Premium, Per Member Per Month Premium,
and the Number of Enrolled Member Months for Children Under 200% FPL (see Exhibit 1)

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APPENDIX 5.D

EXHIBIT 4

EXPANDED PROGRAM:
CALCULATION OF TOTAL PREMIUM COST SHARING FOR EXPANDED POPULATIONS;
PROGRESSIVE PREMIUM SHARING FOR CHILDREN UNDER 200% FPL AND ADULTS BETWEEN 100-200% FPL

Uninsured Adults between 100-200% FPL

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Per Member Per Month (PMPM)	$157.43	$165.54	$174.11	$183.17	$192.75
(PMPM) assuming Managed Care Savings	$149.56	$153.12	$161.05	$169.43	$178.29
Yearly Premium Equivalent	$1,795	$1,837	$1,933	$2,033	$2,139

Poverty Level	Percent of Eligible Enrollment (2)	Percent of Premium	Total Eligible Premium Obligation Costs (3)				
			Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
under 100%	100.0%	0%	$0	$0	$0	$0	$0
100-<110%	11.3%	7.5%	$0	$600,533	$1,273,199	$1,516,868	$1,596,178
110-<120%	11.3%	15.0%	$0	$1,201,065	$2,546,398	$3,033,736	$3,192,356
120-<130%	11.3%	22.5%	$0	$1,801,598	$3,819,597	$4,550,604	$4,788,533
130-<140%	11.3%	30.0%	$0	$2,402,131	$5,092,796	$6,067,472	$6,384,711
140-<150%	11.3%	37.5%	$0	$3,002,664	$6,365,995	$7,584,340	$7,980,889
150-<160%	8.7%	45.0%	$0	$2,746,793	$5,823,520	$6,938,044	$7,300,802
160-<170%	8.7%	52.5%	$0	$3,204,592	$6,794,106	$8,094,385	$8,517,602
170-<180%	8.7%	60.0%	$0	$3,662,391	$7,764,693	$9,250,725	$9,734,402
180-<190%	8.7%	67.5%	$0	$4,120,190	$8,735,279	$10,407,066	$10,951,202
190-<200%	8.7%	75.0%	$0	$4,577,989	$9,705,866	$11,563,407	$12,168,003
Totals	100%		$0	$27,319,946	$57,921,448	$69,006,646	$72,614,677

(1) Managed care savings are assumed to be 5% in FFY 1996 and 7.5% in all subsequent Waiver years, FFY 1997 - FFY 2000.

(2) See Expanded Caseload Appendix, Exhibit 2, for the number of eligibles within each poverty level.

(3) The premium cost sharing for each of the waiver years equals the product of the following:

Percent of Eligible Enrollment, Percent of Premium, Per Member Per Month Premium,

and the Number of Enrolled Member Months for Children Under 200% FPL (see Exhibit 1)

(a) Adults Under 100 FPL (see Exhibit 1, Adults Under 100% FPL).

(b) Adults Between 100-200% FPL (see Exhibit 1, Adults Between 100-200% FPL).

APPENDIX 5.D

EXHIBIT 5

EXPANDED PROGRAM:
IMPACT OF PREMIUM COST SHARING BY INCOME LEVEL AND HOUSEHOLD SIZE CLASSIFICATION

Monthly Premium Amounts

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Children (Under 21 years of age) Under 200% FPL	$67.29	$68.90	$72.47	$76.25	$80.24
Uninsured Adults between 100-200% FPL	$149.56	$153.12	$161.05	$169.43	$178.29
Family of 4 (2 Adults, 2 Children)	$434	$444	$467	$491	$517
Family of 1 (1 Adult)	$150	$153	$161	$169	$178

Poverty Level	Waiver Year 1: FFY 1996											
	Family of 4 Total Premium Obligation Cost				Single Child Premium Obligation Cost				Family of 1 Premium Obligation Cost			
	Percent of Premium	Income Level per Month	Premium	Pct. of Income	Percent of Premium	Income Level per Month	Premium	Pct. of Income	Percent of Premium	Income Level per Month	Premium	Pct. of Income
under 100%	0%	$1,196	$0	0.0%	0%	$1,196	$0	0.0%	0%	$581	$0	0.0%
100-<110%	8%	$1,315	$33	2.5%	8%	$1,315	$5	0.4%	8%	$639	$11	1.8%
110-<120%	15%	$1,435	$65	4.5%	15%	$1,435	$10	0.7%	15%	$697	$22	3.2%
120-<130%	23%	$1,555	$98	6.3%	23%	$1,555	$15	1.0%	23%	$755	$34	4.5%
130-<140%	30%	$1,674	$130	7.8%	30%	$1,674	$20	1.2%	30%	$813	$45	5.5%
140-<150%	38%	$1,794	$163	9.1%	38%	$1,794	$25	1.4%	38%	$871	$56	6.4%
150-<160%	45%	$1,913	$195	10.2%	45%	$1,913	$30	1.6%	45%	$929	$67	7.2%
160-<170%	53%	$2,033	$228	11.2%	53%	$2,033	$35	1.7%	53%	$987	$79	8.0%
170-<180%	60%	$2,153	$260	12.1%	60%	$2,153	$40	1.9%	60%	$1,046	$90	8.6%
180-<190%	68%	$2,272	$293	12.9%	68%	$2,272	$45	2.0%	68%	$1,104	$101	9.1%
190-<200%	75%	$2,392	$325	13.6%	75%	$2,392	$50	2.1%	75%	$1,162	$112	9.7%

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APPENDIX 5.D

EXHIBIT 6

EXPANDED PROGRAM:
PREMIUM COST SHARING WITH TRANSACTION COSTS
BY INCOME LEVEL AND HOUSEHOLD SIZE CLASSIFICATION (1)

Children (Under 21 years of age) Under 200% FPL

Poverty Level	Percent of Eligible Enrollment (2)	Total Eligible Premium Obligation Costs including Transaction Fee Costs				
		Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
under 100%	52.2%	$0	$0	$0	$0	$0
100-<110%	4.8%	$77,092	$222,146	$324,562	$352,163	$382,230
110-<120%	4.8%	$149,306	$434,453	$637,499	$692,316	$752,051
120-<130%	4.8%	$221,519	$646,760	$950,436	$1,032,469	$1,121,872
130-<140%	4.8%	$293,732	$859,068	$1,263,373	$1,372,622	$1,491,693
140-<150%	4.8%	$365,945	$1,071,375	$1,576,309	$1,712,775	$1,861,514
150-<160%	4.7%	$425,352	$1,246,164	$1,834,029	$1,992,927	$2,166,120
160-<170%	4.7%	$495,455	$1,452,267	$2,137,820	$2,323,138	$2,525,132
170-<180%	4.7%	$565,558	$1,658,369	$2,441,611	$2,653,349	$2,884,144
180-<190%	4.7%	$635,660	$1,864,471	$2,745,401	$2,983,561	$3,243,156
190-<200%	4.7%	$705,763	$2,070,574	$3,049,192	$3,313,772	$3,602,169
Totals	100%	$3,935,383	$11,525,647	$16,960,232	$18,429,093	$20,030,079

(1) Transaction fee projected to be $7.50 per family (3.4 individuals), or $2.21 per eligible. Only applies to population between 100-200% FPL.
(2) See Expanded Caseload Appendix, Exhibit 2, for the number of eligibles within each poverty level.

APPENDIX 5.D

EXHIBIT 6

EXPANDED PROGRAM:
PREMIUM COST SHARING WITH TRANSACTION COSTS
BY INCOME LEVEL AND HOUSEHOLD SIZE CLASSIFICATION (1)

Uninsured Adults between 100-200% FPL

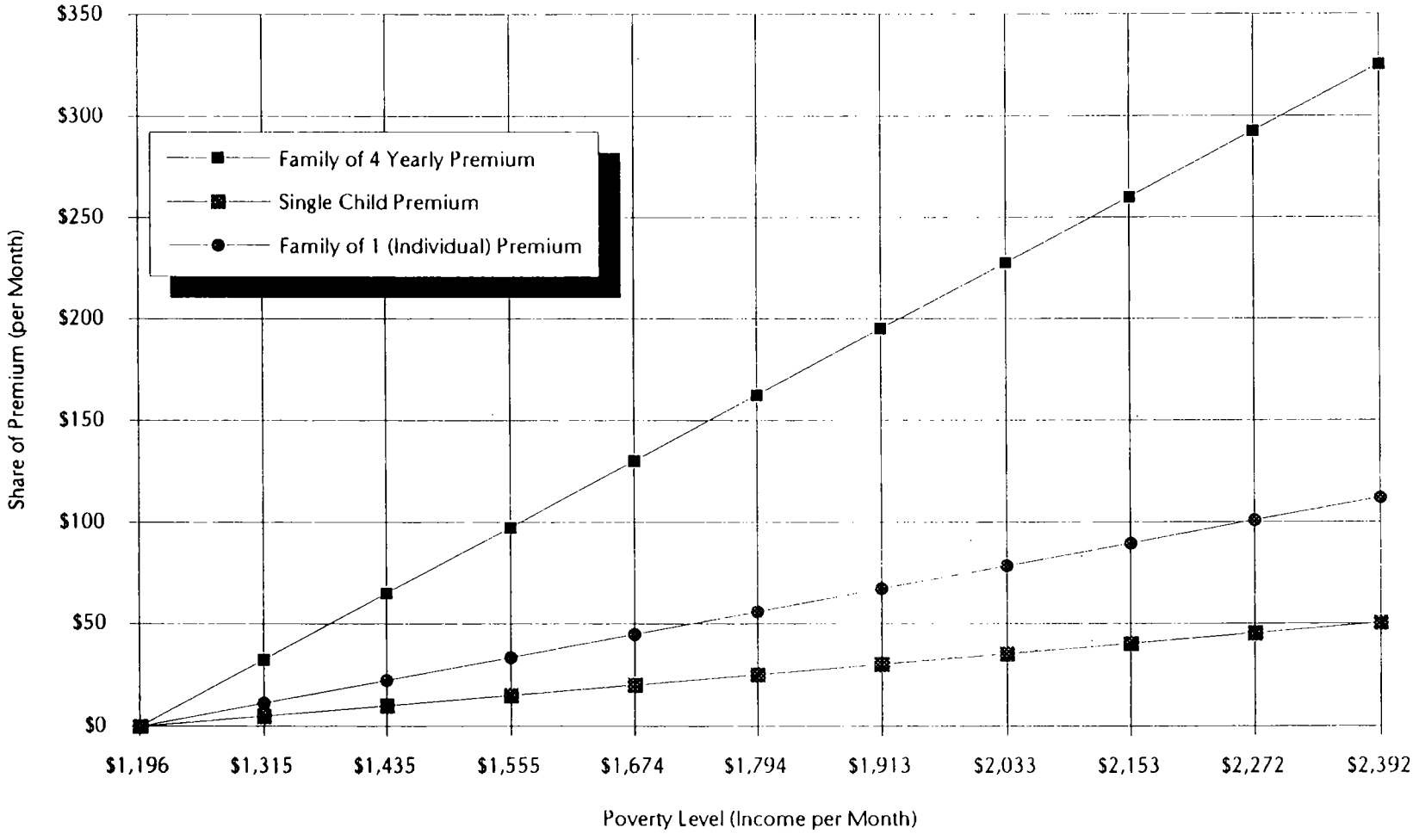
Poverty Level	Percent of Eligible Enrollment (2)	Total Eligible Premium Obligation Costs including Transaction Fee Costs				
		Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
under 100%	100.0%	$0	$0	$0	$0	$0
100-<110%	11.3%	$0	$618,364	$1,295,305	$1,543,513	$1,623,705
110-<120%	11.3%	$0	$1,218,896	$2,568,504	$3,060,381	$3,219,883
120-<130%	11.3%	$0	$1,819,429	$3,841,703	$4,577,249	$4,816,061
130-<140%	11.3%	$0	$2,419,962	$5,114,902	$6,094,116	$6,412,239
140-<150%	11.3%	$0	$3,020,494	$6,388,100	$7,610,984	$8,008,416
150-<160%	8.7%	$0	$2,760,386	$5,840,371	$6,958,356	$7,321,786
160-<170%	8.7%	$0	$3,218,185	$6,810,958	$8,114,697	$8,538,587
170-<180%	8.7%	$0	$3,675,984	$7,781,545	$9,271,037	$9,755,387
180-<190%	8.7%	$0	$4,133,783	$8,752,131	$10,427,378	$10,972,187
190-<200%	8.7%	$0	$4,591,582	$9,722,718	$11,583,719	$12,188,987
Totals	100%	$0	$27,477,064	$58,116,236	$69,241,429	$72,857,239

(1) Transaction fee projected to be $7.50 per family (3.4 individuals), or $2.21 per eligible. Only applies to population between 100-200% FPL.
(2) See Expanded Caseload Appendix, Exhibit 2, for the number of eligibles within each poverty level.

APPENDIX 5.D

EXHIBIT 7

EXPANDED PROGRAM:
SHARE OF PREMIUM COSTS BY POVERTY LEVEL



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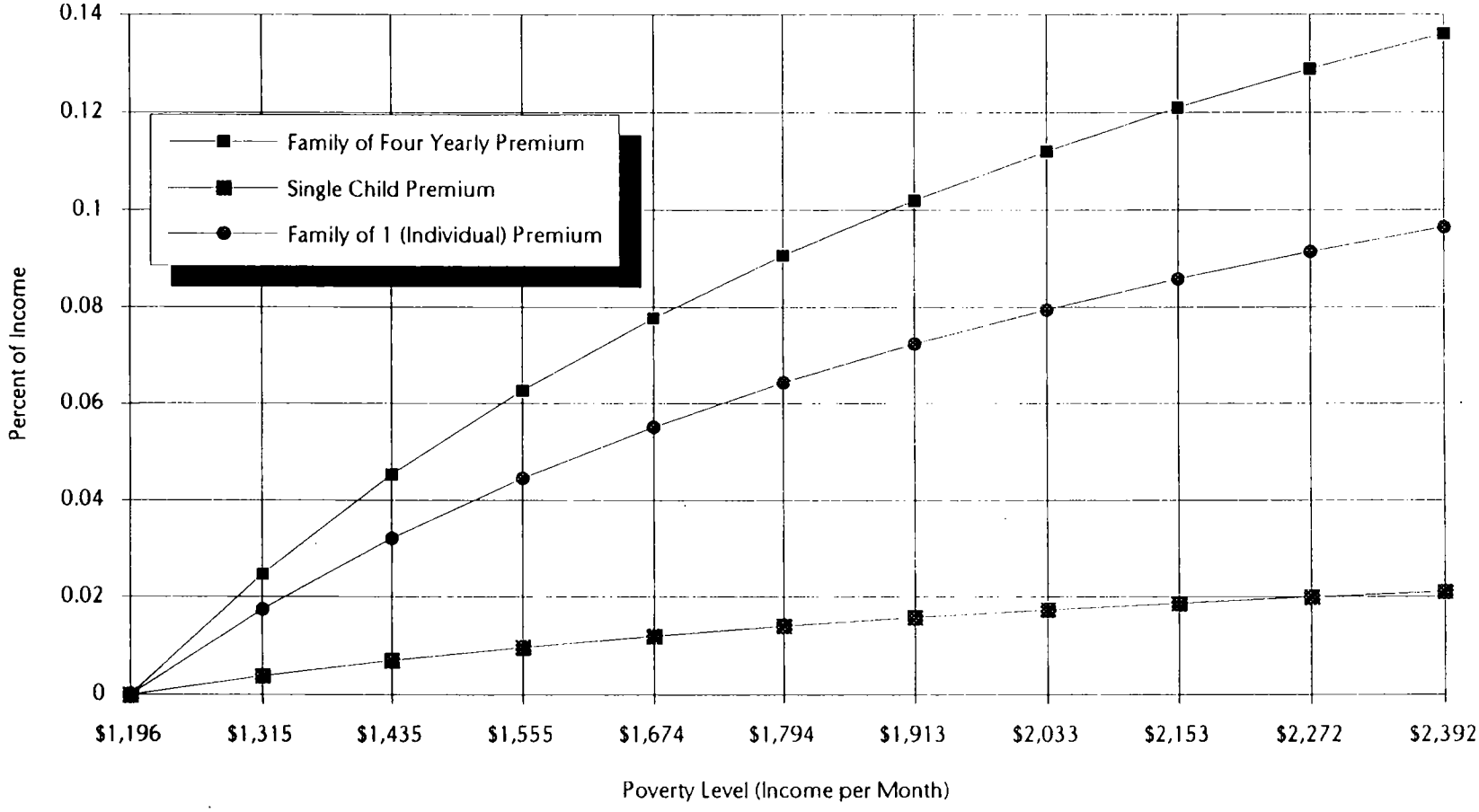
APPENDIX 5.D

EXHIBIT 8

EXPANDED PROGRAM:
PREMIUM COSTS AS A PERCENT OF INCOME BY POVERTY LEVEL



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APPENDIX 5.D

EXHIBIT 9

EXPANDED PROGRAM:
COST ESTIMATES FOR EXPANDED PROGRAM (1), (2), (3)

Children (Under 21 years of age) Under 200% FPL

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Expanded Caseload Member Months	295,068	847,237	1,187,245	1,226,582	1,267,224
Per Member Per Month (PMPM)	$70.83	$74.49	$78.35	$82.43	$86.75
PMPM Cost Assuming Managed Care Savings (4)	$67.29	$68.90	$72.47	$76.25	$80.24
Expanded Waiver Program Costs	**$19,855,022**	**$58,373,905**	**$86,041,952**	**$93,525,005**	**$101,682,261**

Uninsured Adults under 100% FPL

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Expanded Caseload Member Months	293,413	829,796	1,051,828	1,051,828	1,051,828
Per Member Per Month (PMPM)	$142.00	$135.65	$143.38	$151.56	$160.20
PMPM Cost Assuming Managed Care Savings	$134.90	$125.48	$132.63	$140.19	$148.18
Expanded Waiver Program Costs	**$39,582,457**	**$104,121,752**	**$139,504,954**	**$147,456,736**	**$155,861,770**

(continued)

(1) Large increase in Expanded Caseload Member Months between the first and second years of the waiver is the result of the geographic phase-in and the low enrollment in the early months of the waiver program.

(2) Expanded caseload represents only those eligibles that have enrolled under the geographically phased-in managed care program. All other eligibles outside the geographic cachement areas are not included in waiver program.

(3) Managed care savings are assumed to be 5% in FFY 1996 and 7.5% in all subsequent waiver years, FFY 1997 - FFY 2000.

(4) Reflects adverse risk selection adjustment for enrolled children between 100-200% FPL (see PMPM Appendix, Exhibit 4).

APPENDIX 5.D

EXHIBIT 9

EXPANDED PROGRAM:
COST ESTIMATES FOR EXPANDED PROGRAM (1), (2), (3)

Uninsured Adults between 100% to 200% FPL

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Expanded Caseload Member Months	0	460,778	928,807	1,051,828	1,051,828
Per Member Per Month (PMPM), (4)	$157.43	$165.54	$174.11	$183.17	$192.75
PMPM Cost Assuming Managed Care Savings (4)	$149.56	$153.12	$161.05	$169.43	$178.29
Expanded Waiver Program Costs	**$0**	**$70,555,442**	**$149,585,701**	**$178,213,908**	**$187,531,869**

Total Expanded Waiver Program

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Expanded Caseload Member Months	588,480	2,137,812	3,167,879	3,330,238	3,370,879
Expanded Waiver Program Costs (5)	**$59,437,479**	**$233,051,099**	**$375,132,607**	**$419,195,649**	**$445,075,900**

(1) Large increase in Expanded Caseload Member Months between the first and second years of the waiver is the result of the geographic phase-in and the low enrollment in the early months of the waiver program.

(2) Expanded caseload represents only those eligibles that have enrolled under the geographically phased-in managed care program. All other eligibles outside the geographic cachement areas are not included in waiver program.

(3) Managed care savings are assumed to be 5% in FFY 1996 and 7.5% in all subsequent waiver years, FFY 1997 - FFY 2000.

(4) Reflects adverse risk selection adjustment (see PMPM Appendix, Exhibit 4).

(5) PMPM is weighted by the Expanded Caseload Member months for each of the expanded populations.

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APPENDIX 5.D

EXHIBIT 10

TOTAL MEDICAID PROGRAM COSTS: ESTIMATES FOR BASELINE AND WAIVER PROGRAMS

Total Baseline Medicaid Program Costs

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000	Totals Across Waiver Years
Existing Program Baseline Costs (excluding Disproportionate Share Payments)	$2,179,955,882	$2,418,785,247	$2,684,789,104	$2,981,084,503	$3,311,146,700	$13,575,761,436
Total Disproportionate Share Payments	$620,568,422	$620,568,422	$620,568,422	$620,568,422	$620,568,422	$3,102,842,110
Expanded Program Costs, Children under 200% FPL, allowable under 1902(r)(2), (1) (2)	$24,519,546	$53,662,400	$67,514,062	$79,004,246	$87,874,822	$312,575,076
Administrative Costs	$22,672,932	$23,871,702	$25,125,801	$25,881,359	$26,660,169	$124,211,963
Total Program Costs	$2,847,716,782	$3,116,887,771	$3,397,997,389	$3,706,538,530	$4,046,250,113	$17,115,390,585
Federal Obligation (3)	$1,693,970,980	$1,855,100,548	$2,023,518,328	$2,208,425,754	$2,412,076,073	$10,193,091,683

Total Medicaid Program Costs under Waiver

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000	Totals Across Waiver Years
Existing Program Costs excluding the FFS Cost of the Existing Caseload to be included in SecureCare	$986,058,391	$1,075,579,416	$1,174,004,135	$1,279,535,819	$1,393,152,694	$5,908,330,455
Special Payments for Essential Services (SPES)	$485,000,000	$448,000,000	$438,000,000	$428,000,000	$418,000,000	$2,217,000,000
Total SecureCare Program Costs, Existing and Expanded Programs	$1,203,162,892	$1,432,765,727	$1,690,738,921	$1,863,419,893	$2,032,183,722	$8,222,271,156
Disabled Pilot Program Costs (Voluntary Enrollment)	$2,090,986	$4,560,140	$6,019,833	$7,768,018	$9,287,340	$29,726,317
Administrative Costs	$26,373,534	$33,728,152	$31,690,129	$32,252,050	$33,355,769	$157,399,634
Total Program Costs	$2,702,685,803	$2,994,633,435	$3,340,453,018	$3,610,975,780	$3,885,979,525	$16,534,727,562
Federal Obligation (4)	$1,622,349,106	$1,798,485,668	$2,006,360,337	$2,169,021,730	$2,334,390,341	$9,930,607,182

(continued)

(1) Disproportionate Share monies included.

(2) Expanded program without waiver is expected to enroll without geographic phase-in but includes expected presentation rates. For calculation see Expanded Caseload Appendix, Exhibit 7.

(3) Federal Match percentage derived from Missouri HCFA-37 program estimates.

(4) Federal Match percentage derived from Missouri HCFA-37 program estimates and adjusted for 59.85% FFP in the "State only" program expenditures that will be included under SecureCare.

APPENDIX 5.D

EXHIBIT 10

TOTAL MEDICAID PROGRAM COSTS:
ESTIMATES FOR BASELINE AND WAIVER PROGRAMS

Financial Impact of Waiver Program

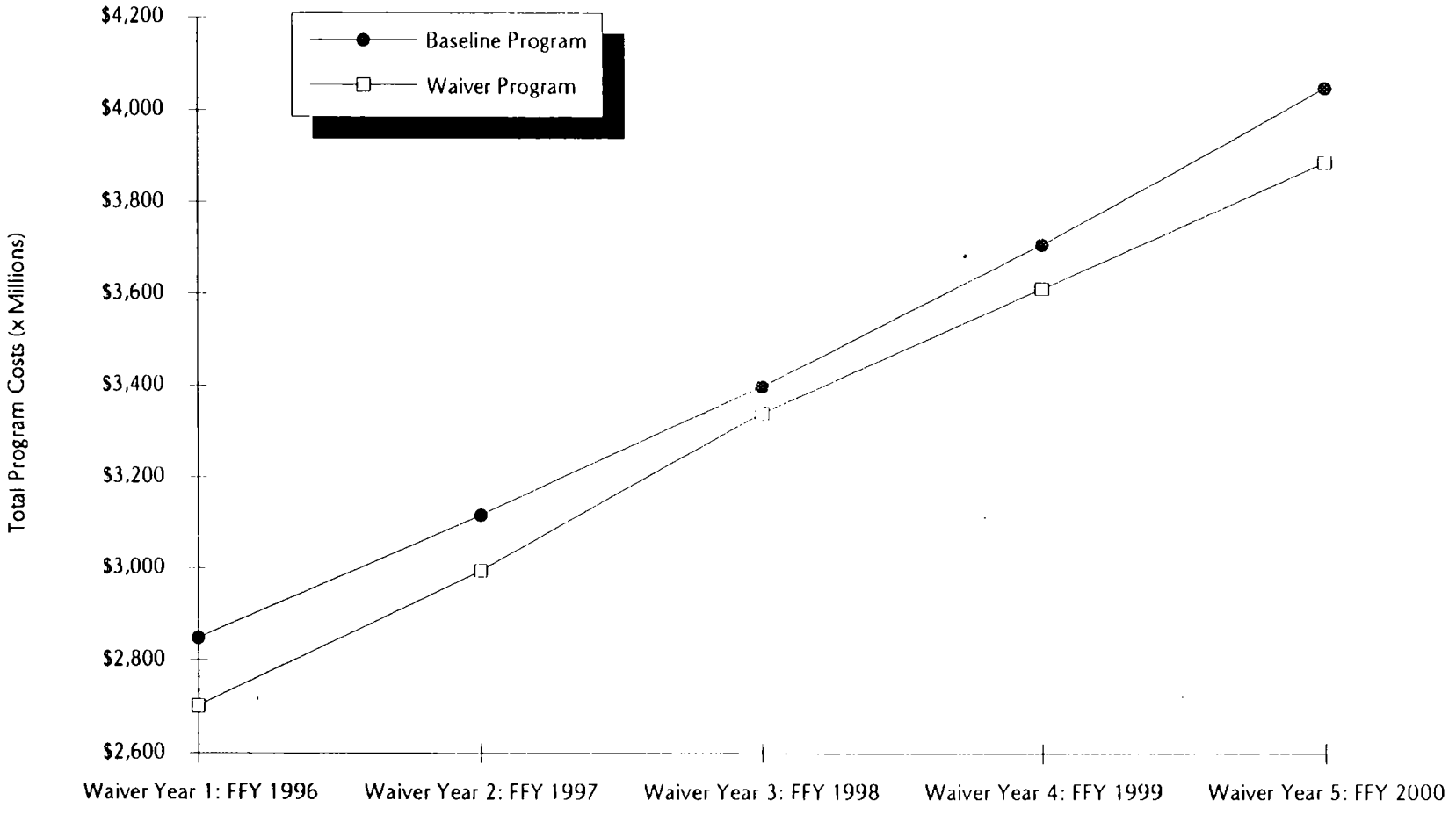
	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000	Totals Across Waiver Years
Total Program Savings/Additional Costs	$145,030,979	$122,254,336	$57,544,371	$95,562,750	$160,270,588	$580,663,023
Federal FFP Savings/Additional Costs	$71,621,874	$56,614,880	$17,157,991	$39,404,024	$77,685,733	$262,484,502

(1) Disproportionate Share monies included.
(2) Expanded program without waiver is expected to enroll without geographic phase-in but includes expected presentation rates.
For calculation see Expanded Caseload Appendix, Exhibit 7.

APPENDIX 5.D

EXHIBIT 11

TOTAL MEDICAID PROGRAM COSTS:
PROGRAM ESTIMATES FOR BASELINE AND WAIVER PROGRAM



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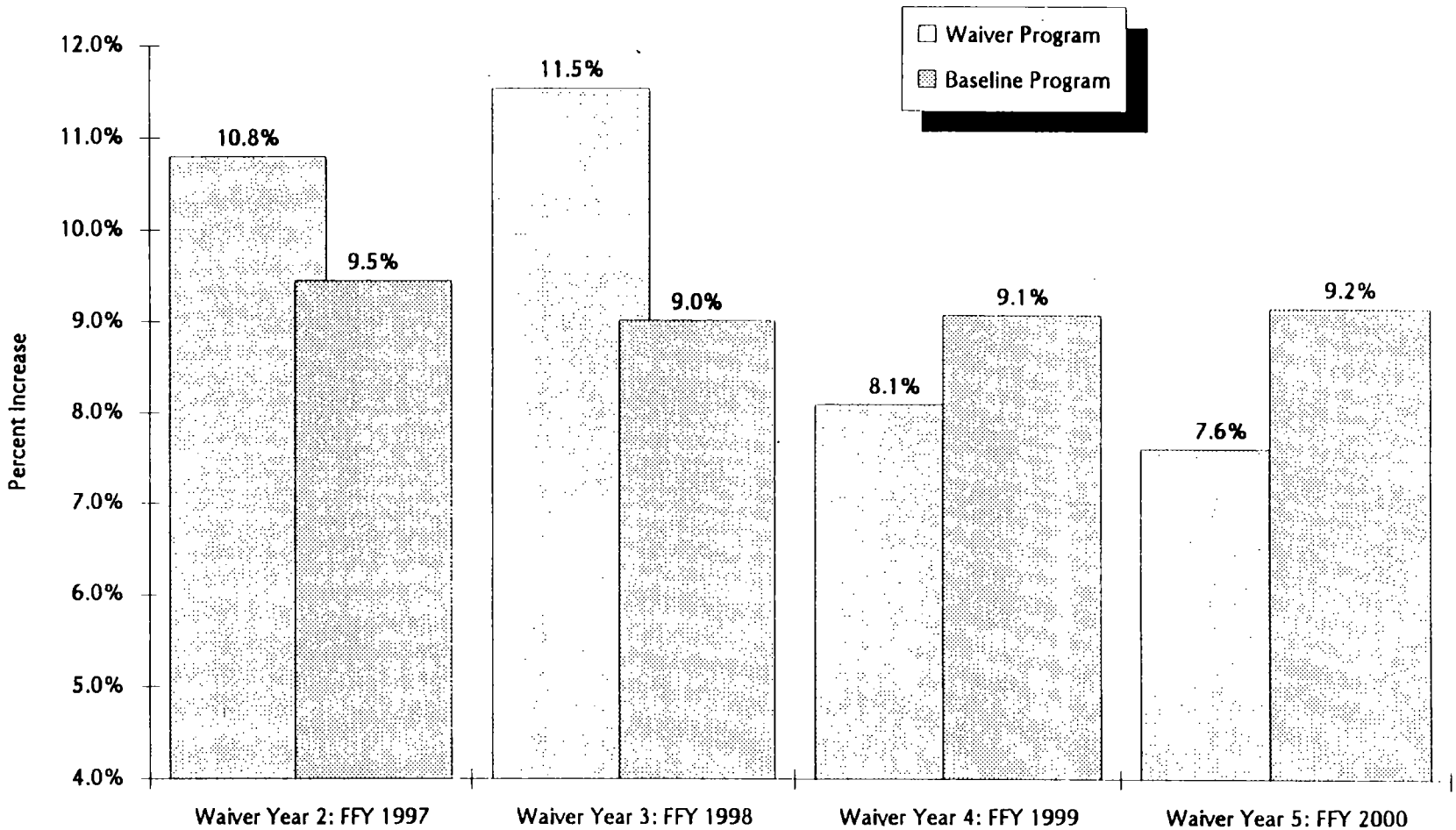
APPENDIX 5.D

EXHIBIT 12

TOTAL MEDICAID PROGRAM COSTS:
CHANGE IN EXPENDITURES FOR THE BASELINE AND WAIVER PROGRAM THROUGHOUT WAIVER YEARS



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JAMES L. (JIM) MATHEWSON
21ST SENATORIAL DISTRICT
142 SOUTH LIMIT
SEDALIA, MISSOURI 65301-3655
816-826-7815

MISSOURI SENATE

JEFFERSON CITY

PRESIDENT PRO TEM
87TH GENERAL ASSEMBLY
ROOM 326, STATE CAPITOL
JEFFERSON CITY, MISSOURI 65101
314-751-4771
TDD 314-751-3969

June 22, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Jefferson City, Missouri 65101

Dear Governor Carnahan:

We are pleased to endorse and support the State of Missouri's 1115 Medicaid Waiver Proposal soon to be submitted to the Health Care Financing Administration.

We have followed the evolution of the proposal with considerable interest and attended several briefing sessions with your staff. As a result, we are impressed with the State's goals to enroll Medicaid eligibles into a managed care plan.

The waiver request is more than just an excellent plan to expand access and managed care to those at or below 100% of poverty: it will also significantly shrink the number of uninsured individuals in the state. In addition, it will produce a statewide health care delivery and financing system which is more rational, more cost effective, and improves the quality and appropriateness of care for those most in need. Perhaps most important of all, the waiver request will serve as a foundation to future steps that will allow the nation to observe how a major state can effectively deal with today's difficult health access problems.

Although there are issues to discuss while structuring a new system, we fully support the Waiver initiative and look forward to providing any additional assistance.

Sincerely,

James L. Mathewson
President Pro Tem

JLM/bfz

Missouri Family Health Council, Inc.

Family Planning and Management Services

1909 Southridge Drive, P O. Box 104475, Jefferson City, Missouri 65110-4475 314/636-4060 Fax 636-2045

Susan Hilton, Executive Director

June 22, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Room 216
Jefferson City, MO 65101

Dear Governor Carnahan:

We are very pleased to write in support of the State of Missouri's 1115 Medicaid Waiver Proposal which will be submitted in the near future to the Health Care Financing Administration.

We have had the opportunity to follow the development of the proposal through our participation on the Technical Advisory Committee. We have appreciated being involved at this level, and have been impressed with the effort that has been made to keep organizations, providers and the general public informed throughout the development phase. The State's goals to enroll Medicaid eligible individuals into a managed care plan are admirable.

We believe the plan will expand access to health care for many people in need in our state, particularly those who are currently uninsured. Additionally, the plan appears more fiscally responsible and more cost effective than our current health delivery system.

There are still many issues to discuss while formulating the new system. However, we fully support the Waiver initiative and look forward to our continued involvement in the future.

Sincerely,

Susan Hilton
Executive Director

MONA
Missouri Nurses Association Organized 1906

P.O. BOX 325 • JEFFERSON CITY, MISSOURI 65102
TELEPHONE (314) 636-4623

BELINDA HEIMERICKS, MS (N), RN
Executive Director

GLORIA BROUN, MSN, RN
President

June 24, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Jefferson City, Missouri 65101

Dear Governor Carnahan:

The Missouri Nurses Association is pleased to endorse and support the State of Missouri's 1115 Medicaid Waiver Proposal soon to be submitted to the Health Care Financing Administration.

As you are aware, the Missouri Nurses Association believes in and has actively lobbied for universal health care coverage for all Missourians. Therefore, we have followed the evolution of the proposal with considerable interest and are impressed with the State's goals to enroll those people eligible for Medicaid into a managed care plan.

We have also been extremely pleased with the State's visionary leadership. The State has created an excellent plan which will significantly reduce the number of uninsured individuals in the state by expanding access and managed care to those at or below 100% of poverty. In addition, the State has recognized and fully incorporated the use of Advanced Practice Registered Nurses as authorized under 335.011 RSMO as quality providers of Medicaid services. Perhaps most important of all, the Waiver request will serve as a foundation to future steps that will allow the nation to observe how a major state can effectively deal with today's difficult health access problems.

Although there are issues to discuss while structuring a new system, we fully support the Wavier initiative and look forward to providing additional assistance during the implementation of the new system.

Sincerely,

Belinda Heimericks, MS(N), RN

Belinda Heimericks, MS(N), RN
Executive Director

American Academy of Pediatrics

Missouri Chapter
1118 E. Walnut Street
Columbia, MO 65203
Chapter Administrator:
Jan K. Frank
314/874-8985
FAX: 314/874-8986

Executive Committee:
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President
Children's Mercy Hospital
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Kansas City, MO 64108
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Bernard A. Griesemer, M.D.
Vice President
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Kansas City, MO 64108
816/234-3054

Gary S. Wasserman, D.O.
Children's Mercy Hospital
2401 Gilham Road
Kansas City, MO 64108
816/234-3053

June 27, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Jefferson City, Missouri 65101

Dear Governor Carnahan:

We, in the Missouri Chapter of the American Academy of Pediatrics, are pleased to endorse and support the State of Missouri's Super Medicaid Waiver Proposal soon to be submitted to the Health Care Financing Administration.

We have followed the evolution of the proposal with considerable interest and are impressed with the State's goals to enroll Medicaid eligibles into a managed care plan.

The waiver request is more than just an excellent plan to expand access and managed care to those at or below 100% of poverty; it will also significantly shrink the number of uninsured individuals in the state. In addition, it will produce a statewide health care delivery and financing system which is more rational, more cost effective, and improves the quality and appropriateness of care for those most in need. Perhaps most important of all, the waiver request will serve as a foundation to future steps that will allow the nation to observe how a major state can deal effectively with today's difficult health access problems.

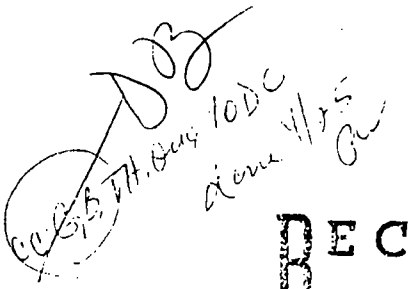
As we move toward improved health care for many improvised children of Missouri, we would like to bring to your attention the great need that exists to protect our academic centers as well as our pediatric hospitals if we are to carry out this most needed approach.

Sincerely,

Jerome A. Grunt, M.D., Ph.D.
President Missouri Chapter
American Academy of Pediatrics

JAG:dmb

St. Louis County
Department of Health



April 14, 1994

Donna Checkett, Director
Division of Medical Services
MO Dept. of Social Services
P.O. Box 6500
Jefferson City, Missouri 65102-6500

Dear Donna:

I am responding to a request by MPHA to review the Medicaid Waiver Plan. It is obvious your committee and many others have put much work into making Medicaid a cost effective quality program.

I believe the managed care approach is an effective way to improve continuity of care and control cost.

It has been my experience that an urgent care center has some problems very similar to those of an E.R. Unless there is a co-pay or some triage "gateperson", clients soon begin to use this system for routine care and neglect keeping regular appointments. This becomes very frustrating for providers who are then faced with delivery of filling prescriptions on persons they do not know with little history of care available. We have found that a triage system with same-day sick appointments works much better during normal business hours with urgicare service available after hours.

I believe that building in a triage system with emphasis on patient education of appropriate use of health care services is an important factor in cost control.

uzz Westfall
ounty Executive

Alpha Fowler Bryan, M.D.
irector

he John C. Murphy
Family Health Center
7065 Helen Avenue
erkeley, MO 63134

Phone: (314) 522-6410
Fax: (314) 522-1435
DD: (314) 854-6446

A second significant cost factor is control of prescription drugs and medical tests. This can be accomplished through parameters of practice or careful utilization review which I believe should be included in the managed care system.

As a member of MPHA I support your efforts to simplify government and increase service.

Sincerely,

Connie Brooks

Connie Brooks RN, M.Ed., MSN, CS
Administrator
John C. Murphy Health Center

PARTNERSHIP FOR CHILDREN

Dedicated to improving conditions for children in the Greater Kansas City area

1055 Broadway, Suite 170
Kansas City, Missouri 64105

(816) 842-7643
Fax • (816) 842-7907

June 13, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Jefferson City, Missouri 65101

Dear Governor Carnahan:

The Partnership for Children enthusiastically supports Missouri's submission of the 1115 Medicaid Waiver Proposal being submitted to the Health Care Financing Administration of the Department of Health and Human Services.

The School District of Independence was able to institute Missouri's Healthy Children and Youth provision of Medicaid EPSDT. They demonstrated how to reach eligible children more successfully. Since that time, I have followed the development of the Waiver and have been very supportive of Missouri's pro-active work of meeting the health care needs of our Medicaid eligible citizens.

The reduction of the number of uninsured citizens, the development of a more cost-effective health care delivery system and the improvement of health care for Missouri's Medicaid eligible citizens are just three reasons why we would support the Waiver.

True health care reform is at hand. We are proud that Missouri is taking a leadership role.

Sincerely,

James M. Caccamo, Ph.D.
Executive Director

MHA
MISSOURI HOSPITAL ASSOCIATION

FAX: (314) 893-2809
Phone: (314) 893-3700

Mailing address:
P.O. BOX 60
JEFFERSON CITY, MISSOURI 65102-0060

Street address:
4712 COUNTRY CLUB DRIVE
JEFFERSON CITY, MISSOURI 65109-4544

CHARLES L. BOWMAN
PRESIDENT

May 5, 1994

The Honorable Mel Carnahan
Governor
Room 216, State Capitol
Jefferson City, MO 65101

Dear Governor Carnahan:

The Board of Trustees of the Missouri Hospital Association voted to endorse the application of the Missouri Department of Social Services to obtain a waiver from the Department of Health and Human Services to allow Missouri to streamline its Medicaid operations. We specifically endorse your efforts to:

- decouple Medicaid from AFDC and other eligibility criteria;
- expand coverage to individuals at higher income levels than currently allowed by law;
- enroll the Medicaid population in managed care;
- simplify administrative responsibilities of the state; and,
- develop a streamlined benefit plan.

We appreciate your leadership in seeking this waiver. We feel that this waiver, when granted, greatly will enhance access to health care for Missouri's uninsured and underinsured. If we may be of further assistance in this matter, please do not hesitate to contact us.

Sincerely,

Charles L. Bowman
President

CLB/cml

Missouri Perinatal Association

P.O. Box 1431
Jefferson City, MO 65102

June 16, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Jefferson City, MO 65101

Dear Governor Carnahan:

The Missouri Perinatal Association (MPA) is pleased to support the State of Missouri's 1115 Medicaid Waiver Proposal soon to be submitted to the Health Care Financing Administration.

MPA is a multi-disciplinary, non-profit membership organization founded in 1978. Members include nurses, physicians, social workers, nutritionists, administrators, other health care professionals, and consumers interested in perinatal health and education. The mission of MPA is to promote families' wellness by improving the health of Missouri women, mothers, children and families during the childbearing years.

It is evident to us that the current, categorical Medicaid system is allowing too many poor Missourians to slip through the cracks; at present, some family members have access to care, while others do not. We believe that expanding access to all individuals at or below 100% of poverty through managed care--providing that quality is monitored as vigorously as cost--is key to delivering health care to an otherwise disenfranchised population. It is our strong hope that the income-eligibility level be revised upwards to at least 200% of poverty as quickly as possible.

We trust that this application will allow our state Medicaid system to move to a point where quality prenatal care can be made available and accessible to every pregnant woman within 30 minute's travel from home, and within to weeks of discovering her pregnancy, and that prenatal care be linked with risk-appropriate delivery services for all women.

Although the implementation of this waiver will raise many new challenges, MPA looks forward to being part of the solution and providing assistance wherever we can.

On behalf of the Board of Directors

Janie Vestal MD

Janie Vestal, MD
President

JV:clw

National Perinatal Association Member

Missouri Academy of Family Physicians

June 27, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Jefferson City, Missouri 65101

Dear Governor Carnahan:

The Missouri Academy of Family Physicians feels the reorganization of the Missouri Medicaid program will be of great benefit to all Missourians. Our Association is pleased to endorse and support the concept of Medicaid waiver from the Health Care Financing Administration.

We are aware of the success of model Medicaid programs which utilize established capitation and managed care concepts. In Missouri, we have had extensive experience with these methods of providing medical care and feel the role of Family Physicians in managed care plans offers significant opportunity for cost containment.

Our Academy has long endorsed universal health coverage. By expanding the number of persons covered by Medicaid, our state can make significant progress toward that goal. We feel Missouri has an opportunity to develop a program of health care coverage which will serve as a foundation to future steps that will allow the nation to observe how a major state can effectively deal with today's difficult health access problems.

We support a Medicaid waiver initiative for our state and anticipate working closely with state officials as this program is developed.

Sincerely,

William D. Soper, M.D.

William D. Soper, M.D.
President
Missouri Academy of Family Physicians

WDS/jl

Executive Director: Jean Larson
8901 State Line, Kansas City, Missouri 64114, Suite 102
(816) 363-0822 MO Wats (800) 942-8347
Fax (816) 363-8901

Missouri Public Health Association

323 Monroe Street Jefferson City, MO 65101 (314) 634-7977

June 20, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Jefferson City, MO 65101

Dear Governor Carnahan:

The Missouri Public Health Association is pleased to support the State of Missouri's 1115 Medicaid Waiver Proposal soon to be submitted to the Health Care Financing Administration.

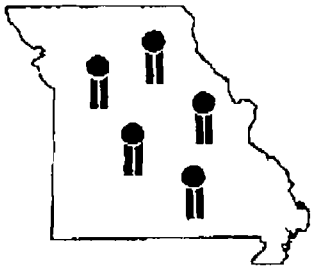
We have closely followed the development of the proposal with considerable interest and attended several briefing sessions. We are pleased that Missouri is among the leading states in structuring a system to expand access and managed care to Medicaid eligible citizens.

Over the past two years, our Association's leading priority has been to support health reform which would improve the access and affordability of quality health care for all Missourians. Public health departments and community health centers play an important role in the delivery of many of the essential prevention and primary care services. We see SecureCare as an important means toward the goal of universal coverage.

MPHA supports the Waiver and looks forward other collaborative opportunities. In support of this initiative, we have formed a committee of represenatives from state and local public health departments, social services agencies, private health care providers, and consumer groups to plan a state conference on managed care.

Sincerely,

Patti Van Tuinen
President



M·A·A·D·A·P

MISSOURI ASSOCIATION OF ALCOHOL AND DRUG ABUSE PROGRAMS

June 27, 1994

The Honorable Mel Carnahan
Governor of Missouri
State Capitol Building
Jefferson City, MO 65101

Dear Governor Carnahan:

On behalf of the Missouri Association of Alcohol and Drug Abuse Programs, I would like to commend you on the development of the SecureCare waiver. SecureCare promises to control Medicaid costs and enhance health security for behavioral and physical health services.

As the single organization representing the collective interests of alcohol and other drug abuse prevention and treatment providers across Missouri, MAADAP supports your efforts in this vital area of health care. We look forward to working with you to further define and implement this important program.

Sincerely,

Brian Treece
Executive Director

1203 MISSOURI BOULEVARD, SUITE B • JEFFERSON CITY, MISSOURI 65109 • (314) 761-4099 • (314) 874-5696*fax*

HA Community Support Services
Affirming Creative Environments
1200 Rogers Street, Suite 200, Columbia, Missouri 65201 Telephone (314) 443-0405 Fax (314) 875-2557

June 27, 1994

The Honorable Mel Carnahan
Office of the Governor
MO Capital Building
Jefferson City, MO 65102

Dear Governor Carnahan:

As the representative to the Missouri Department of Mental Health Medicaid Waiver Steering Committee, for the Missouri Association of Psychosocial Rehabilitation Services: it is MY responsibility to let you know that our association fully supports the Secure Care Waiver submission to the United States Department of Health and Human Services.

As you know, Missouri Association of Psychosocial Rehabilitation Services represents the providers who deliver nearly all of the community based care for the Department of Mental Health. We have been encouraged and reassured by the clarifications and communications that your office and the Department of Social Services have provided about the nature of mental health coverages in the Secure Care package, and the processes for articulating such.

Thank you for your concern about Missouri citizens.

Very truly yours,

Nancy Melise, ACSW, LCSW
Executive Director

NM/dm