OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will also continue work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____MISSISSIPPI_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

/s/ Haley Barbour_____ 3-15-06
(Signature of Governor, or designee, of State/Territory) (Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Robert L. Robinson, DBA Position/Title: Executive Director

Name: Maria D. Morris Position/Title: Bureau Director/CHIP

Name: David Maatallah Position/Title: Office Director/ Finance &Accounts

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for **(Check appropriate box)** **(42 CFR 457.70)**:

1.1.1 ☒ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. A combination of both of the above.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

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

Date Plan submitted:	July 29,1998
Date Plan effective:	July 1, 1998
Date Amendment #1 submitted:	August 1, 1998
Date Amendment #1 effective:	January 1, 2000
Date Amendment #2 submitted:	September 22, 1999
Date Amendment #2 effective:	January 1, 2000
Date Amendment #3 submitted:	July 6, 2000
Date Amendment #3 effective:	October 1, 2000
Date Amendment #4 submitted:	July 3, 2001
Date Amendment #4 effective:	July 1, 2001
Date Amendment #5 submitted:	September 30, 2002
Date Amendment #5 effective:	January 1, 2005
Date Amendment #6 submitted:	December 29, 2005
Date Amendment #6 effective:	January 1, 2005

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

Demographics

According to latest available census reports, Mississippi's population is 2,844,658 (2000 Census).

According to the Behavorial Risk Factor Surveillance System, 16% of Mississippi's population is currently under 100% of the Federal Poverty Level, or approximately 340,479. Twenty-one percent of the families in Mississippi have children under age 18.

According to the 2000 Census reports, there are 873,214 (30.7%) children ages less than 19 in the State of Mississippi. ***See*** Attachment A for breakdown by county.

Medicaid Eligibles

According to 1998 reports generated by the Division of Medicaid's decision support system, Mississippi Medicaid Information Retrieval System (MMIRS), there are 223,184 Mississippi children ages less than 19 currently enrolled in Medicaid. ***See*** Attachment B for breakdown by county.

Based on Heritage Foundation estimates combined with the State's estimates, there could be as many as 41,751 children less than 19 years of age eligible for Medicaid who are currently not enrolled as of 1998. ***See*** Attachment A for breakdown by county. These 41,751 children are targeted as part of an outreach initiative to find and enroll Medicaid eligible children under Title XIX.

CHIP

Mississippi originally implemented its SCHIP in July 1998 with a Medicaid expansion program for children 15-18 years at 100% FPL. This phase of the program ended as of October 01, 2002. To date, the State's CHIP targets all children in the state below age 19 who are below 200% FPL, not eligible for Medicaid coverage, and have no other health coverage. According to Census and MMIRS data, it was estimated there are approximately 65,000- 85,000 uninsured children in the state below age 19 who are below 200% FPL and

do not qualify for Medicaid. The goal is to assess these children for CHIP eligibility under a health coverage package. As of August 2005, over 66,000 children are enrolled in CHIP.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102) (a) (2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Medicaid is the only other public health insurance program in the State of Mississippi for children. Health services are provided in Mississippi to uninsured and Medicaid enrolled children by private physicians, 82 Mississippi County Health Department clinics operating at 110 sites, 22 FQHC's, newly-funded school health nurses, and several Indian Health Service Clinics. In addition, the Children's Medical Program provides specialty care to uninsured and Medicaid enrolled children with special health care needs. The Department of Mental Health (DMH) provides mental health services to children through their Community Mental Health Clinics on a sliding scale fee arrangement based upon the patient's declared income. These entities currently identify and help enroll children who are eligible for Medicaid coverage and will be used to identify and enroll non-covered children who are eligible to participate in the CHIP as well as the Medicaid program. The Department of Education (DOE) has signed a memorandum of understanding with the Division of Medicaid (DOM) to assist with the identification and enrollment for CHIP. Program information presentations are provided on an on-going basis to schools and Head Starts in the state, inviting families to apply for health benefits (Medicaid or CHIP). Applications, pamphlets, flyers, and posters are being widely distributed together with informational brochures in Spanish and Vietnamese, as well as English.

Mississippi State Health Department

This agency administers services and programs for Medicaid recipients and uninsured families and children in maternal-child health, environmental health (including lead screening for children under the Medicaid Early, Periodic Screening Diagnostic Treatment (EPSDT) program, family planning, newborn genetic screening, well child health services, immunizations, and tuberculosis control. The Health Department operates a county health department system of 110 sites, 18 regional home health offices and 92 WIC distribution centers. The Health Department partners with the Division of Medicaid in providing targeted case management services for infants and toddlers and for EPSDT children and perinatal high-risk pregnancy case management services. This agency is an integral part of the outreach system for finding Medicaid and CHIP eligible children.

Mississippi Department of Human Services (DHS)

This agency provides programs and services to needy and disadvantaged individuals and families through TANF, food stamps, employment/training programs, literacy programs, child care programs, child abuse and neglect services, foster care and adoption services, child support and medical support enforcement services, and providing care and treatment for children properly committed to the agency's custody. With offices in all 82 counties, this agency is integral in targeting and enrolling Medicaid and CHIP eligible children.

Department of Rehabilitation Services

This agency provides rehabilitation services to eligible disabled adults and children who are on Medicaid or who are uninsured. In addition, it currently processes and renders decisions on applications for Social Security Disability and Supplemental Security Income Disability and for the State's Medicaid blind and disabled coverage groups. This agency will be integral in identifying and enrolling children eligible for Medicaid and CHIP.

Department of Mental Health (DMH)

This agency provides all services in the state for the mentally ill, emotionally disturbed, alcoholic, drug dependant and mentally retarded persons. These services are provided through a system of Community Mental Health Centers in eight regions of the state, several ICF-MRs, and a system of acute and residential programs. These programs serve the Medicaid population, as well as the uninsured, particularly children. This agency will be integral in identifying and submitting application forms to the state agency with responsibility for determining eligibility for Medicaid and CHIP.

Department of Education (DOE)

The Department of Education has attached a form to its application for the School Lunch Program for families to indicate an interest in the CHIP. Interested families are provided applications to be brought to the Medicaid region office. DOE has been very cooperative in distributing CHIP materials (see page 4) and is eager to participate in CHIP outreach. Various initiatives in partnership with the Department of Education are used to identify, enroll and retain eligible children in Medicaid and CHIP such as screening of potential eligibles through the Free and Reduced Lunch Program or the $20 Incentive Program which ended January, 2005.

Mississippi Division of Medicaid (DOM)

This agency provides a statewide system of medical assistance, health care, remedial

and institutional services under Titles XXI, XIX and XVIII of the Social Security Act. In partnership with the Department of Human Services, Department of Health, Department of Education, and the Department of Mental Health, the Division identifies and enrolls Medicaid eligible children. This partnership has been maintained and strengthened to identify and enroll CHIP eligible children. The State Department of Health and the Department of Mental Health serve as providers of services to Medicaid*/CHIP* eligible children and to uninsured children. The Division of Medicaid works with these agencies and a statewide coalition of other partners to identify, enroll and retain eligible children for MS Health Benefits Program (Medicaid and CHIP). In addition, the Division of Medicaid has expanded its school-based providers of EPSDT screening and treatment services. Through this avenue, the Medicaid agency will be able to utilize the schools to identify Medicaid eligible and CHIP eligible children. With out-stationed workers in federally qualified health centers (FQHCs), disproportionate share hospitals (DSH) hospitals and Health Department Clinics, the Medicaid agency will utilize these service providers to identify Medicaid and CHIP eligible children. The Medicaid agency will increase its reliance on primary care providers (PCP) through its fee-for-services providers to disseminate information about eligibility for both Medicaid and CHIP for children through its Medical Advisory Committee. The Medicaid agency established the State CHIP Steering Committee that is composed of representation from the Department of Finance and Administration (DFA), Department of Health, Department of Human Services (DHS), and the Department of Mental Health in order to be comprehensive in its approach in the provision of quality health services to all children. This committee meets quarterly, reviews program operations and gives recommendations.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

There is currently no public-private health initiative for children in Mississippi. The Blue Cross/Blue Shield Caring Program for Children was the only health program that resembled a public-private partnership. This program has been discontinued. According to Blue Cross/Blue Shield, this program was closed due to lack of private contributions for matching purposes. The last child was removed from the program in December 1997, but the program had not accepted any new enrollees for over a year prior to that.

Because of lack of any private insurance initiatives for children and families unable to afford any other kind of health care coverage, the 1998 Mississippi Legislature did establish the Mississippi Children's Health Insurance Program Commission, which explored the feasibility of a public-private partnership for children's health care for targeted low-income children who do not qualify for Medicaid. DOM has received a HRSA State Planning Grant to identify potential health policy options for the under and uninsured through the establishment of public-private partnerships. The final

report from that grant will be available by August 31, 2006.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as Title V, that provide health services for low-income children to increase the number of children with health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

As discussed previously, there are no other public or private programs designed to provide creditable coverage for low-income children. DOM does have on-going communication with private health insurance groups, present at their professional meetings, provides program information and updates and has an exchange of referrals.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations.
(Section 2102)(a)(4) (42CFR 457.490(a))

Organization and Management

Coverage under the separate insurance program, as described above, is administered by the State and School Employees Health Insurance Management Board (hereinafter referred to as the Health Insurance Management Board), through an agreement with the Division of Medicaid. This Board is established by 25-15-303 of the Mississippi Code (refer to Attachment E). The Board has the sole authority to promulgate rules and regulations governing the operations of the insurance plans under its purview and is vested with all legal authority necessary and proper to perform this function including, but not limited to the following for the State and School Employees' Health Insurance Plan:

(a) Defining the scope and coverage provided by the insurance plans;
(b) Seeking proposals for services or insurance through competitive processes where required by law and selecting service providers or insurers under procedures provided for by law; and
(c) Developing and adopting strategic plans and budgets for the insurance plan.

The Department of Finance and Administration (DFA) is authorized by this same law to provide staff assistance to the Board and to employ a State Insurance Administrator, who is responsible for the day-to-day management and administration of the insurance plans. The State Insurance Administrator oversees the Office of Insurance which also has responsibility

for administering the State Agencies' Workers' Compensation Trust and the State and School Employees' Life and Health Insurance Plan.

Eligibility and Outreach

Eligibility for CHIP is determined in the same manner and by the same agency as eligibility for Medicaid, the Division of Medicaid. For applications and re-determinations, a face-to-face interview is required. The State has designed a "short form" that closely resembles the federal model, which is available at community health centers, health department clinics, and other providers of primary care and on the internet. This application entitled MS Health Benefits Application with informational materials and updates is made available on an on-going basis, to these providers, to Head Start Programs, Tribal Nations, community action agencies, hospitals, primary care providers, pediatricians, family practitioners and schools throughout the state. On-going trainings are provided to the public. Special educational and outreach materials will continue to be developed and distributed by the State for CHIP. Applications may be taken at any of the 30 Medicaid regional offices or the established out stationed sites. Over 250 out stationed sites have been established across the state at hospitals, nursing facilities, health departments, medical clinics and federally qualified health centers.

In addition, DOM has established a Memorandum of Understanding with the Department of Education to assist with the identification and retention of eligible children, education of parents and distribution of applications and information. All families identified through this mechanism will be provided with an application or referred to the local regional Medicaid office.

The appeals process for eligibility denials for CHIP is the same process currently in place for denial of Medicaid eligibility. The process is set forth in state statute at Miss. Code Ann. Section 43-13-116.

Management of Coverage

The Health Insurance Management Board contracted with Blue Cross/Blue Shield of MS (BCBSMS) through a competitive bid process for health insurance coverage for children eligible for CHIP. The Board defines the minimum level of benefits to be provided by the contractor (see Section 6.2) BCBSMS provides enrollment, financial accounting services, and insurance coverage for the eligible population on a statewide basis. Such services include, but are not limited to, the following:

(a) Collecting enrollment data on eligible participants;
(b) Responding to inquiries from potentially eligible families;
(c) Providing a description of coverage and ID cards to enrolled participants;
(d) Adjudicating claims;
(e) Implementing an internal appeals process;
(f) Processing payment to providers:

(g) Responding to inquiries and complaints from members and providers;
(h) Implementing appropriate utilization management;
(i) Ensuring adequate access to providers;
(j) Producing required and requested reports;
(k) Submitting encounter data to the State's Data Management Vendor;
(l) Maintaining proper financial controls and reporting.; and
(m) Conducting required data matches.

Coverage is made available to eligible children on a "guaranteed issue" basis. There are no exclusions for pre-existing conditions, and coverage is granted on a "guaranteed renewable" basis.

Employer-Sponsored Insurance Subsidy Feature

(Implementation of this feature is on hold for an indefinite time.)

For eligible children in families with access to employer-sponsored health insurance, the Plan will pay the insurance premium for coverage under the employer's plan if the plan meets the following criteria:

(a) The employer's plan meets benchmark coverage; the employer is willing to participate in the Children's Health Insurance Program;
(b) The employer contributes at least 50 percent of the premium for family coverage (employee + children);
(c) The family has not enrolled the child(ren) in group coverage through the employer any time within the previous six months;
(d) The cost to CHIP for purchasing coverage from the employer is no greater than the payment the program would make if the child(ren) were enrolled in the State's Plan (excluding payments for services excluded as pre-existing under the employer's plan); and
(e) The family applies for the full premium contribution available from the employer.

The State has developed a checklist of benefits included in the benchmark coverage (refer to Attachment H). The State's actuary will use this checklist to evaluate the benefits allowed under the employer's plan based on the Summary Plan Description of the employer's plan. If an employer-sponsored plan has a benefit design that makes it difficult to evaluate with the checklist, the State's actuary will be asked to evaluate whether the employer-sponsored plan is equivalent to benchmark coverage.

The following is a summary of the procedures that will be followed to determine if an employer-sponsored plan is eligible for premium subsidy:

(a) The actuary will compare the employer's Summary Plan Description to the benchmark plan's benefits on a benefit by benefit basis (see attached checklist).
(b) If the employer's plan of benefits match the benchmark plan's benefits on a benefit

by benefit basis (without regard to cost sharing), the employer's plan will be considered to have passed this criterion and will be evaluated for cost.

(c) If the employer's plan of benefits does not match on a benefit by benefit basis, the plan may be rejected by the actuary as not equivalent to the benchmark plan or may undergo a full actuarial analysis by the actuary to compare the overall actuarial value of the employer's plan to the actuarial value of the benchmark plan (without regard to cost sharing). This decision will be made by the actuary based upon the degree of difference in the particular benefit and whether or not there is another benefit where the employer's plan exceeds the benchmark plan. If a benefit in the employer's plan does not meet the level of the benchmark plan, but the difference is minor, and there is another benefit where the employer's plan exceeds the benchmark plan, the actuary may perform the full actuarial analysis if in his opinion there is a reasonable potential that the full actuarial value of the employer's plan is equivalent to or greater than the benchmark plan. In order to be approved, the employer's plan must have an overall actuarial value equivalent to or greater than 100% of the benchmark's plan actuarial value and the actuarial value in the following categories of benefits must be equal to or greater than 75% of the actuarial value of the coverage in the respective category in the benchmark plan: prescription drugs, mental health services, vision services, and hearing services.

(d) The State will submit copies of the benefit comparisons and actuarial analyses to CMS upon request. Children who qualify for payment of premiums under an employer-sponsored plan will receive "secondary" or "wrap-around" supplemental coverage under Mississippi's CHIP plan to cover deductibles, co-insurance, co-payments, and pre-existing conditions. Providers will be asked to file claims for these amounts after the primary carrier has allowed benefits and issued an explanation of benefits. In order to ensure that families are not required to pay more than the specified co-payments, if any, under CHIP, the State's communications to providers upon the implementation of CHIP will include the following information on cost sharing:

(a) There are no cost sharing requirements for children enrolled in CHIP except for the minimal co-payments for families over 150% of FPL;
(b) Any charges for deductibles, co-insurance, or co-payments under employer-sponsored plans are to be filed with the State's CHIP insurer;
(c) The federal law governing CHIP prohibits cost sharing with respect to benefits for well child care, including immunizations, and families may not be required to pay for these services at the point of service; and
(d) There is no cost sharing for American Indian/Alaska Native children.

In addition, the State's communications to providers upon the implementation of this premium-assistance feature will include claim filing procedures for both primary and secondary claims.

3.2. Describe the utilization controls under the child health assistance provided under

the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

The contractor selected by the Health Insurance Management Board to provide insurance coverage for CHIP must have acceptable policies and procedures for utilization and disease management. These include at a minimum pre-certification for inpatient hospital stays and certain surgical and diagnostic procedures, as well as case management services for high cost or long-term conditions and a toll-free number staffed by nurses appropriately trained in disease management and triage. The health plan must also ensure that there are proper appeal procedures in place to preclude denial of care that is appropriate and medically necessary.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ Geographic area served the Plan: Statewide.
4.1.2. ☒ Age: Birth through 18 years of age
4.1.3. ☒ Income: 200% FPL.
4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):
4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): Currently residing in the State with intent to stay.
4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):
4.1.7. ☒ Access to or coverage under other health coverage: Children who are eligible for Medicaid or who have creditable health coverage under another plan at the time of application will not eligible for CHIP.
4.1.8. ☒ Duration of eligibility: 12 months from the date of initial determination or until the child reaches age 19 years or becomes eligible for Medicaid whichever occurs first. A face to face interview is required for application and re-determination.
4.1.9. ☐ Other standards (identify and describe): The applicant child over age 1 year must provide a social security number in accordance with provision **(42.CFR457.340(b))**

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

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

Eligibility for CHIP is determined in the same manner and by the same agency and workers as eligibility for Medicaid. Upon application and re-determination, a face-to-face interview is required. The State has a "short form" that closely resembles the federal model. These applications are available at community health centers, Head Start, health department clinics, and other providers of care as well all the local DHS offices, and on the DOM website.

The State provides twelve months of continuous enrollment in CHIP, except in instances where children reach the age of 19 years or become eligible for Medicaid, leave the State, acquire other insurance,[2] become deceased, or at parent's request. CHIP cases may also close if the State discovers and validates the enrollee had other insurance at the time of application or re-determination.

Due to the transition of eligibility from the Department of Human Services to the Division of Medicaid that occurred January 1, 2005, Medicaid specialists are entering all application information during the re-determination and application processes. An appointment for a face-to-face interview is mailed to CHIP enrollees during the month prior to the annual renewal month. Provision of verifications of income, dates of birth and social security numbers for members being re-determined is required. Once the information is received, the case is handled much like the initial application. The recipients are first screened for Medicaid. If ineligibility based on income and age is established, then the redetermination is screened for CHIP.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1 Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health

benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**
During the application process, the applicants self-report their current insurance status.

The State uses a single application entitled MS Health Benefits Program (MHB) to apply for both Medicaid and CHIP. A completed MHB application is processed at the local regional Medicaid office by the Medicaid specialist. During the application process, the applicant is required to appear for an in-person interview, provide the household's income verification and social security numbers for all applying. The first step at application is to determine the household's income level and the age of the children involved. This information is first used to determine if any household member is Medicaid eligible in any of the state's Medicaid programs. If ineligibility for Medicaid is established, the applicants are screened for CHIP.

The MHB application asks the applicants to provide information regarding any coverage under group health plan or health insurance coverage that anyone applying has had in the last six months. Once the application has been processed and approved, the private insurer notes issues as they arise on claims submitted that indicate other health insurance coverage or reports from parents/providers of other coverage. These reports are then followed up on at the state level in the CHIP Office and appropriate action is taken based on the resulting discovery.

Due to the transition of eligibility determination from the Department of Human Services to the Division of Medicaid that occurred January 1, 2005, Medicaid specialists are entering all application information during the re-determination and application processes. An appointment for a face-to-face interview is mailed to CHIP enrollee during the month prior to the annual renewal month. Provision of verifications of income, dates of birth and social security numbers for members being re-determined is required. Once the information is received, the case is handled much like the initial application. The recipients are first screened for Medicaid. If ineligibility based on income and age is established, then the re-determination is screened for CHIP.

As previously mentioned, if the private insurer for CHIP discovers a claim submitted listing any other insurance coverage the insurer provides this information to the state CHIP Office for further investigation. Pending the findings, the CHIP case may or may not be closed.

In Mississippi, the children of public agency employees with access to the State employee insurance plan who meet all eligibility requirements of CHIP can be covered under CHIP. The employees must pay the full cost of insurance coverage for dependent children without any subsidy from the State in accordance to policy guidance under Section 2110(b)(2)(B) of Title XXI.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Eligibility for CHIP will be determined by Medicaid specialists primarily located at local regional Medicaid offices as well as at out stationed sites, according to the same methodology currently used to determine eligibility for Medicaid. Only if applicants are determined ineligible for Medicaid, will they be considered for CHIP.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

As fore mentioned, the State uses a single application entitled MS Health Benefits Program (MHB) to apply for Medicaid and CHIP. A completed MHB application will be processed at the regional Medicaid office by Medicaid specialist. It will be screened for eligibility for Medicaid first. If that screening results in ineligibility, the applicant is screened for eligibility for CHIP.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

The applicant's current insurance status is self-reported during the application and re-determination processes. As previously mentioned, if the private insurer for CHIP discovers a claim submitted listing any other insurance coverage for a recipient, the insurer provides this information to the state CHIP Office for further investigation. Pending the findings, the CHIP case may or may not be closed.

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The state's plan amendment to eliminate the 6-month waiting period was approved October 2000. As a condition of that approval, the State monitors on a monthly basis the number of children approved with prior creditable health insurance in the last six months as declared on the MBH application. When the number of children enrolled with prior coverage is 15% of the total CHIP children approved as of 10/2000, the State will seek to implement a new waiting period. To date, the percentage of children approved with prior coverage has remained below 4% of the total CHIP enrollment since 10/2000.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify

specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describes:
(On hold)

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.
Six months

The minimum employer contribution.
Not specified

The cost-effectiveness determination.
The cost of covering a child through the employer plan must not exceed cost under the State program.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Leadership of the Mississippi Band of Choctaw Indians has been contacted directly, and a targeted strategy of outreach and determination of eligibility has been developed. As needed, training on the completion of the MHB application provided to identify staff of the Choctaw community. Out stationed Medicaid specialists are routinely scheduled on site to take MHB applications. (Refer to Section 8.2 regarding the waiver of cost sharing requirements for American Indian/Alaskan Native children.)

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Medicaid and CHIP applications and information are distributed statewide through health care providers and a statewide coalition of collaborative partners. Families are informed of the availability of coverage under Titles XIX and XXI. Outreach activities consist of efforts

to identify and enroll children who are eligible for both Medicaid and CHIP. As previously discussed, Medicaid is the only public health insurance program for children in the state, and there is currently no private health coverage for children who cannot afford to pay for it. Thus, Medicaid and CHIP enrollment represent the only viable public alternatives for the State's children to have creditable insurance coverage in this targeted population. The State recognizes the importance of outreach to families of children likely to be eligible for assistance and to encourage them to enroll and retain their children, the State has done the following:

(a) Reduced barriers to participation by using the same "short form" currently used to determine eligibility for Medicaid and CHIP; by streamlining income verification processes; dispensing with resource and asset tests for children, and by wide dissemination of application and information.;
(b) Engaged in provider education efforts because providers are a vital link to this population;
(c) Initiated cooperative efforts with the State Department of Health, the Department of Human Services, Department of Mental Health, Department of Education, the Department of Rehabilitation Services and Head Start regarding public awareness of these two programs;
(d) Developed statewide coalitions to assist with the dissemination of materials and conducting a variety of outreach strategies such as health fairs and forums, development of informational fliers, posters, and other promotional items;
(e) Engaged the print media as a means to educate providers;
(f) Coordinated a number of community based initiatives to educate families with potentially eligible children;
(g) Partnered with entities and programs through local and state inter-agency councils, school-based health programs, including Head start, and other community organizations whose missions include services to families and children;
(h) Out stationed Medicaid specialists at FQHCs, Disproportionate Share Hospitals, County Health Departments, Indian reservations, and through school-based EPSDT providers; and
(i) Coordinated with the Department of Education, mechanisms to identify children in the targeted population for outreach activities and assessment for eligibility as well as provide another avenue for dissemination of information about CHIP.

Beyond administering outreach, the State will ensure that staff at the appropriate state agencies will be well trained to respond to inquiries from the public and provide progress reports to advocacy groups, the Legislature, and other interested parties.

Special Populations

The State works continuously with the Native American and Asian populations with the Medicaid and CHIP programs. The State has out stationed Medicaid specialists at Native Americans' Health Facilities across the state in order to identify and enroll the children in either CHIP or Medicaid. On-going communication, technical assistance, and program

information are provided to the coastal Catholic Charities Refugee Center that provides services to the largest Asian population in the State.

Teens will be reached through the Division of Medicaid's outreach partners such as Jackson Hinds Community Health Center, Children Defense Fund who go into schools to conduct outreach both for eligibility and for access to EPSDT services. The State will also rely on the State Health Department clinics to help identify and enroll teens through family planning and other health outreach programs. The State has also identified public events, school, church, and community teen activities that reach teens.

The State works closely with the Mississippi School for the Deaf and the Mississippi School for the Blind to identify and enroll visually and hearing impaired children and also rely on their staff as resources for developing print and visual material for hearing impaired and audio material for vision impaired children and their families to learn about the CHIP program. The State also has sign language interpreters available to help with outreach and enrollment for hearing impaired children and limited English speaking population.

The State has targeted two areas of limited English proficiency: Spanish speaking families in the Southern part of the state and Vietnamese speaking families throughout the state. The State has subscribed to a language line service to help with on-site screening and enrollment processes. The State has printed materials in these two languages.

The State has begun to work closely with a children's advocacy group, Children's Health Matters, a coalition of advocates working through Catholic Charities, who is helping the Division of Medicaid define and find solutions to various barriers to enrollment in health programs for children, including Medicaid and CHIP. This group has committed their resources to address as many of these barriers along with the state as is possible. This partnership has been formalized through a funded contractual agreement.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))**

(If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See Instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage@ is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
Coverage includes that of the State and School Employees' Health Insurance Plan's High Option Coverage for Children plus dental and vision coverage.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison **(Please provide a sample of how the comparison will be done)**

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

Must be pre-certified as medically necessary and includes the following:

(1) Hospital room and board (including dietary and general nursing services)
(2) Use of operating or treatment rooms.
(3) Anesthetics and their administration.
(4) Intravenous injections and solutions.
(5) Physical therapy.
(6) Radiation therapy.
(7) Oxygen and its administration.
(8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms.
(9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs.
(10) Dressings and Supplies, sterile trays, casts, and orthopedic splints.
(11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.
(12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations.
(13) Intensive, Coronary, and Burn Care Unit services.
(14) Occupational therapy.
(15) Speech therapy.

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**
See Physician Services and Surgical Services.

6.2.3. ☒ Medical services **(Section 2110(a)(3))**

Includes the following:

(1) In-hospital medical care.
(2) Medical care in the physician's office, enrollee's home, or elsewhere.
(3) Surgery.
(4) Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an Accidental Injury. Covered medical expense must be incurred as a direct result of an accidental injury to natural teeth and medical treatment must begin within ten days of the accidental injury.
(5) Administration of anesthesia.
(6) Diagnostic services, such as clinical laboratory examinations, x-

ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests.

(7) Radiation therapy.

(8) Consultations.

(9) Psychiatric and psychological service for nervous and mental conditions.

(10) Physicians assisting in surgery, where appropriate.

(11) Emergency care or surgical services rendered in a practitioner's office including but not limited to surgical and medical supplies, dressings, casts, anesthetic, tetanus, serum and x-rays.

(12) Well child assessments, including vision screening, laboratory tests and hearing screening, according to recommendations of the U.S. Preventive Service Task Force.
Vision and hearing screening are to be included as part of the periodic well child assessments.

(13) Routine immunizations (according to ACIP guidelines)-Vaccine is purchased and distributed through the State Department of Health. The health plan will reimburse providers for the administration of the vaccine.

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

Certain surgeries must be pre-certified as medically necessary.

Benefits are provided for the following covered medical expenses furnished to the enrollee by an Ambulatory Surgical Facility:

(1) Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure.

(2) Pre-operative preparation.

(3) Use of facility (operating rooms, recovery rooms, and all surgical equipment).

(4) Anesthesia, drugs and surgical Supplies.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

Covered as medical services (refer to 6.2.3.).

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**

The following drugs and medical supplies are covered:

(1) Legend drugs (federal law requires these drugs be dispensed by prescription only)

(2) Compounded medication of which at least one ingredient is a legend drug

(3) Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape)
(4) Disposable insulin needles/syringes
(5) Growth hormones
(6) Insulin
(7) Lancets
(8) Legend contraceptives
(9) Retin-A
(10) Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets)
(11) Vitamin and mineral supplements, when prescribed as replacement therapy

The following are excluded:
(1) Anabolic steroids (e.g., Winstrol, Durabolin)
(2) Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder
(3) Anti-wrinkle agents (e.g., Renova)
(4) Charges for the administration or injection of any drug
(5) Dietary supplements
(6) Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi)
(7) Minerals (e.g., Phoslo, Potaba)
(8) Minoxidil (Rogaine) for the treatment of alopecia
(9) Non-legend drugs other than those listed as covered
(10) Pigmenting/depigmenting agents
(11) Drugs used for cosmetic purposes
(12) Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorrette, Nicoderm, etc)
(13) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes
(14) Any medication not proven effective in general medical practice
(15) Investigative drugs and drugs used other than for the FDA approved diagnosis
(16) Drugs that do not require a written prescription
(17) Prescription Drugs if an equivalent product is available over the counter
(18) Refills in excess of the number specified by the practitioner or any refills dispensed more than one year after the date of practitioner's original prescription

6.2.7. ☐ Over-the-counter medications. **(Section 2110(a)(7))**

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**
Certain diagnostic tests must be pre-certified.

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**
Infertility services are excluded.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

(1) Benefits for Covered Medical Expenses are paid for medically necessary inpatient psychiatric treatment of an enrollee for a period of up to thirty (30) days annually.
(2) Benefits for covered medical expenses are provided for Partial Hospitalization for a period of up to sixty (60) days annually.
(3) Certification of medical necessity by the Insurer's Utilization Review Program is required for admissions to a hospital.

Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

Benefits for Covered Medical Expenses for treatment of nervous and mental conditions on an outpatient basis are limited to 52 visits annually.
Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse

6.2.12. ☒ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). **(Section 2110(a)(12))**

Rental of Durable Medical Equipment is covered for temporary therapeutic use; provided, however, at the Insurer's discretion, the purchase price of such equipment may be allowed. To be Durable Medical Equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the enrollee's home.

Prosthetic or Orthotic Devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or congenital abnormalities

are covered services. Benefits are available for the initial placement, fitting, and purchase of Prosthetic or Orthotic devices that require a prescription by a physician and for the repair or replacement when medically necessary. Shoes are not covered except for the following: (1) a surgical boot which is part of an upright brace, (2) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes, and (3) a custom fabricated shoe in the case of a significant foot deformity.

Eyeglasses (limited to one per year) and hearing aids (limited to one every three years) are covered services.

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

Supplies provided under the Plan which are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling an enrollee to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use in the enrollee's home.

6.2.14. ☒ Home and community-based health care services (See Instructions) **(Section 2110(a)(14))**

Services and supplies required for the administration of Home Infusion Therapy regimen must be (1) medically necessary for the treatment of the disease; (2) ordered by a practitioner; (3) as determined by the Insurer's Utilization Review Program capable of safe administration in the home; (4) provided by a licensed Home Infusion Therapy provider coordinated and pre-certified by the Insurer's Utilization Review Program ; (5) ordinarily in lieu of inpatient hospital therapy; and (6) more cost effective than inpatient therapy.

Benefits for home health nursing services must be approved by the Insurer's Utilization Review Program in lieu of hospitalization. Benefits for nursing services are limited to $10,000 annually.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15)**

Benefits include nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered and supervised by a practitioner and when the services rendered require the technical skills of an RN or LPN.

Benefits are provided for covered medical expense when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered.

Benefits for private duty nursing services are provided for an illness or injury that the Insurer's Utilization Review Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that the Insurer's Utilization Review Program determines to require the skills of an RN or LPN. Benefits for nursing services provided in an enrollee's home must be approved by the Insurer's Utilization Review Program in lieu of hospitalization. Benefits for nursing services are limited to $10,000 annually. (This limit does not apply to nurse practitioner services.)
No nursing benefits are provided for:
(1) Services of a nurse who ordinarily lives in the child's home or is a member of the child's family;
(2) Services of an aide, orderly or sitter; or
(3) Nursing services provided in a Personal Care Facility.

Benefits are provided for confinement in a skilled nursing facility for up to 60 days per benefit period, subject to utilization management requirements.

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

Benefits are allowed for elective abortion only when documented to be medically necessary in order to preserve the life or physical health of the mother.

6.2.17. ☒ Dental services **(Section 2110(a)(17))**

Covered dental services are limited to $1500 each calendar year

(1) Benefits will be provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD).
   a. Bitewing X-rays - as needed, but no more frequently than once every six months;
   b. Complete Mouth X-ray and Panoramic X-ray - as needed, but no more frequently than once every twenty-four (24) months;
   c. Prophylaxis - one every six months; must be separated by six full months;
   d. Fluoride Treatment - limited to one each six month period;
   e. Space Maintainers - limited to permanent teeth through age 15 years; and
   f. Sealants - covered up to age 14 years, every thirty-six months.

(2) Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below, and are limited to $1500 each calendar year.

a. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration;
b. Stainless steel crowns to posterior and anterior teeth;
c. Porcelain crowns to anterior teeth only;
d. Simple extraction;
e. Extraction of an impacted tooth;
f . Pulpotomy, pulpectomy, and root canal; and
g. Gingivectomy, gingivoplasty and gingival curettage.

Other Dental Services (The Calendar Year Maximum does not apply to these services.)

(1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an accidental injury.
(2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. These services must be pre-certified.
(3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is subject to a lifetime maximum benefit of $5,000 per member. This lifetime maximum will apply regardless of whether the temporormandibular / craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse, as follows:

(1) Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance abuse treatment.
(2) Certification of medical necessity by the Insurer's Utilization Review Program is required for admissions to a hospital or residential treatment center.
(3) Benefits for inpatient and outpatient care shall not exceed $8,000 during a Benefit Period and shall not exceed a Lifetime Maximum of $16,000 except a $1,000 per benefit period will be provided for inpatient and outpatient alcohol abuse once the enrollee's $16,000 lifetime maximum is exhausted.
(4) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

(1) Benefits are provided for covered medical expenses for medically necessary Intensified Outpatient Programs in a hospital, an approved licensed alcohol abuse or chemical dependency facility, or an approved drug abuse treatment facility.
(2) Benefits are provided for covered medical expenses for substance abuse treatment while not confined as a hospital inpatient.
(3) Benefits for inpatient and outpatient care shall not exceed $8,000 during a Benefit Period and shall not exceed a Lifetime Maximum of $16,000 except a $1,000 per benefit period will be provided for inpatient and outpatient alcohol abuse once the enrollee's $16,000 lifetime maximum is exhausted.
(4) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

6.2.20. ☒ Case management services **(Section 2110(a)(20))**

Medical Case Management may be performed by the Utilization Review Program for those children who have a catastrophic or chronic condition. Through medical case management, the Utilization Review Program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies which are not otherwise covered. The decision to provide extended or alternative benefits is made on a case-by-case basis to covered children who meet the Utilization Review Program's criteria then in effect. Any decision regarding the provision of extended or alternative benefits is made by the Utilization Review Program.

6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the enrollee's practitioner and provided by a licensed physical therapist.

Benefits are provided for medically necessary occupational therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist.

Benefits are provided for medically necessary speech therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech, delayed language development, or articulation disorders.

Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

Benefits are provided for inpatient and home hospice services, subject to utilization management requirements. Benefits for hospice services are limited to an overall lifetime maximum of $15,000.

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See Instructions) **(Section 2110(a)(24))**

Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.

Transplant Benefits:

(1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:
- (i) The enrollee or provider obtains prior approval from the Insurer's Utilization Management Program; and
- (ii) The condition is life-threatening; and
- (iii) Such transplant for that condition is the subject of an ongoing phase III clinical trial; and
- (iv) Such transplant for that condition follows a written protocol that has

been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and

(v) The enrollee is a suitable candidate for the transplant under the medical protocols used by the Insurer's Utilization Management Program.

(2) In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.

(3) Benefits are provided for transportation costs of recipient and two other individuals to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to $10,000.

(4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:

(i) The following expenses are covered:

- A search for matching tissue, bone marrow or organ
- Donor's transportation
- Charges for removal, withdrawal and preservation
- Donor's hospitalization

(ii) When only the recipient is a enrolled in the Program, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient's contract.

(iii) When both the recipient and the donor are enrolled in the Program, the donor is entitled to benefits under the donor's contract.

(iv) When only the donor is a Plan participant, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient.

(v) If any organ or tissue is sold rather than donated to the enrollee, no benefits are payable for the purchase price of such organ or tissue;

Manipulative therapy is a covered medical expense but benefits shall not exceed $1,500 annually.

Benefits are provided for medically necessary services and supplies required for the treatment of injury or disease of the eye which fall within the legal

scope of practice of a licensed optometrist. Benefits are provided for annual routine eye examinations, eyeglasses, and the fitting of eyeglasses.

Benefits are provided for diabetes self-management training and education, including medical nutrition therapy, for the treatment of diabetes, subject to a limitation of $250 per benefit period.

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

Professional ambulance services to the nearest hospital, which is equipped to handle the enrollee's condition in connection with covered hospital inpatient, care; or when related to and within 72 hours after accidental bodily injury or medical emergency whether or not inpatient care is required.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

Limitations and Exclusions:

a. For convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician for an enrollee who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall benefits be provided if the enrollee was admitted to a hospital for his or her own convenience or the convenience of his or her physician, or that the care or treatment provided did not relate to the condition for which the enrolled child was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the enrolled child was hospitalized and then only during such time as such services are medically necessary.
b. For cosmetic purposes, except for correction of defects incurred by the enrollee while covered under the Program through traumatic injuries or disease requiring surgery.
c. For sex therapy or marriage or family counseling.
d. For custodial care, including sitters and companions.
e. For equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, etc.).
f. For procedures, which are Experimental/Investigative in nature.

g. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
h. For services and supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim to be medically necessary.
i. For services which the Insurer's Utilization Review Program determines are not medically necessary for treatment of injury or illness.
j. For services provided under any federal, state, or governmental plan or law including but not limited to Medicare except when so required by federal law.
k. For nursing or personal care facility services i.e., extended care facility, nursing home, or personal care home, except as specifically described elsewhere.
l. For treatment or care for obesity or weight control including diet treatment, gastric or intestinal bypass or stapling, or related procedures regardless of any claim of medical necessity or degree of obesity.
m. For inpatient rehabilitative services consisting of the combined use of medical, social, educational or vocational services, or any such services designed to enable enrollees disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the Insurer's Utilization Review Program.
n. For outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable enrollees disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the enrollee's physician and provided by a licensed therapist.
o. For care rendered by a provider, (physician or other provider) who is related to the covered enrollee by blood or marriage or who regularly resides in the enrolled child's household.
p. For services rendered by a provider not practicing within the scope of his license at the time and place service is rendered.
q. For treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease.
r. For reversal of sterilization regardless of claim of medical necessity.
s. For elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother.
t. For charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim.
u. For travel, whether or not recommended by a physician, except as provided for under Transplant Benefits.
v. Because of diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
w. For treatment of any injury arising out of or in the course of employment or any sickness entitling the enrollee to benefits under any Workers' Compensation or Employer Liability Law.
x. For any injury growing out of a wrongful act or omission of another party for which

injury that party or some other party makes settlement or is legally responsible; provided, however, that if the enrollee is unable to recover from the responsible party, benefits shall be provided.

y. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b) (1)(B)(ii))**; **OR**

6.3.2. ☐ The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1 Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference Section 6.2.1- 6.2.28.** **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2.The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3.The coverage must be provided through the use of a

community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system.** **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

See response to Section 9.3.

In order to ensure that children receive appropriate and timely access to routine childhood immunizations, and in order to ensure that the State is able to properly monitor immunization rates for CHIP children, the Division of Medicaid purchases vaccine through the State Department of Health which distributes it to providers in a manner similar to that used for the Vaccine for Children Program. The vaccine is supplied to providers free of charge, and

providers must agree to participate in the State's Immunization Registry. The health plan providing health insurance coverage for CHIP children reimburses for the administration of the vaccine. In addition, all county health departments in the state provide childhood immunizations for a minimal administration fee, and the State Department of Health bills the CHIP health plan for the administration fee for all immunizations provided to CHIP children so that there is no cost to the family.

Providers participating in the health plan's network are prohibited from requiring any cost sharing for preventive services, including immunizations, rendered to children enrolled in CHIP.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards
7.1.2. ☐ Performance measurement
7.1.3. ☒ Information strategies

The health plan submits encounter data to the Data Management Vendor (DMV) used by the Department of Finance and Administration for participants in the State and School Employees' Health Insurance Plan. The vendor currently is The MEDSTAT Group. MEDSTAT compiles the data and provides reports, such as HEDIS-like reports, as well as allows the development of ad hoc reports using the MEDSTAT system. The enrollment file is matched annually with the State Immunization Registry to determine the immunization status of two-year olds enrolled in CHIP.

The health plan distributes a member booklet to all enrollees describing their coverage. The plan also annually conducts a consumer satisfaction survey.

7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: **(Section 2102(a)(7)(B)) (42CFR 457.495)**

The health plan is required to meet certain access standards under the contract for the Children's Health Insurance Program. These access standards include assuring that at least 85 percent of children have access to a primary care physician within 15 miles in urban/suburban areas and 25 miles in rural areas, and a hospital within 25 miles in urban/suburban areas and 45 miles in rural areas. The health plan conducts a GeoAccess analysis of providers in the network compared to the enrollment file to measure access levels.
The health plan is required to conduct a member satisfaction survey at least annually. This survey includes questions related to access to health care services.

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood

and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

Through MEDSTAT**,** the State monitors the number and rate of well-child visits by age group. By matching with the State Immunization registry, the State determines the immunization rate for two year olds.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

The State requires the health plan to provide access to emergency services based on the State's definition of a medical emergency, which is "the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in: (1) permanently placing the patient's health in jeopardy, (2) serious impairment of bodily functions; or (3) serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences. Determination of a medical emergency shall be based on presenting symptoms rather than final diagnosis.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollees' medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

The health plan provides case management services for children with complex, often high cost, medical conditions. If care is not available in-network, approval is given to access care on an out-of-network basis.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

The health plan reports on the rate of response to utilization management contacts.

The health plan's decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient and federal regulations. These decisions are determined within the 14 days time frame for medical requests. For health services, the State uses health insurance law, not the Medicaid fair hearing process since CHIP is a health insurance plan.

Section 8. Cost Sharing and Payment **(Section 2103(e))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES
8.1.2. ☐ NO**, Skip to Question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. **(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))**

8.2.1. Premiums: None
8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

Requirement	≤150% FPL	151%-175% FPL	176% - 200% FPL
Per doctor visit	None	$5.00	$5.00
Per ER visit	None	$15.00	$15.00
Out-of-Pocket Maximum	NA	$800	$950

8.2.4. Other: Co-payments as outlined in the following table.

No cost sharing is applied to preventive services, including immunizations, well child care, routine preventive and diagnostic dental services, routine dental fillings, routine eye examinations, eyeglasses, or hearing aids.

There is no cost sharing for American Indian/Alaska Native children.

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

All cost sharing requirements are described in the member booklet(s).

The Rules and Regulations governing the program are filed with the Secretary of State's office. Information regarding cost sharing is included in this document. Interested parties may access this document from the Department of Finance and Administration's website. Questions can also be addressed by calling the toll free Customer Service number of the health plan.

Individual participants are notified of cost sharing responsibilities through their member booklets. The individual identification card also indicates cost sharing amounts and cumulative maximum. The health plan maintains the cost sharing accounting for the participant. When a participant has met his/her out of pocket maximum, the health plan sends a letter to the participant indicating that no further co-payments should be made for the remainder of the calendar year. The participant is instructed to present this letter when future health services are sought, or request the provider to contact the health plan regarding this issue.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☐ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

The Health Plan providing coverage tracks each family's out-of-pocket expenses. If a family's annual aggregate cost-sharing amount reaches the out-of-pocket amount noted in Section 8.2.4 (which is below 5 percent of the family's annual income) the family will receive notification that no further cost sharing is required for the remainder of the year. This notification can be used by the family to document to health care providers that no co-payments are to be collected for services provided.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

There is no cost sharing for American Indian/Alaska Native children. These children are classified separately so that there is no cost sharing applied regardless of income.

Through the application process, the applicant self-declares his/her race and ethnicity. DOM, the agency responsible for eligibility determination, notifies the health plan of an American Indian/Alaska Native enrollee through a specific code in the enrollment data transfer process. DOM currently assigns out stationed Medicaid specialist to take

applications at the Indian Reservation.

The health plan enrolls American Indian/Alaska Native children in a separate contract type, which has no cost sharing requirements, regardless of poverty category. The member booklet sent to these participants explains that there is no out of pocket expenses for covered services.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**
Families are not dis-enrolled due to non-payment of copayments. (Member booklet explains that a provider may refuse service if unpaid)

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- ☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**
- ☐ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- ☐ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of

June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

1. The infrastructure of the Mississippi Medicaid agency will be able to accommodate all critical facets of outreach and eligibility determination for the Title XXI program.
2. Previously uninsured children who will potentially be eligible for Mississippi's Title XXI program will be identified through ongoing outreach activities involving other state agencies, social/healthcare providers, schools, Head Start, community/faith-based organizations, and advocates.
3. Low income children who were previously without health insurance coverage will have health insurance coverage through Mississippi's Title XXI program.
4. Children enrolled in CHIP will have adequate access to primary care, inpatient care, and pharmacy services.
5. Children enrolled in CHIP will receive appropriate preventive and primary care services.
6. Families of CHIP enrollees will be surveyed annually regarding their satisfaction with the services provided under the Program

9.2 Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

Performance Goal for Objective 1:

The capacity within the Mississippi Division of Medicaid was appropriately expanded or modified to conduct outreach, enrollment and eligibility determination activities as needed to enroll uninsured eligible children. These areas include data systems modification, eligibility determinations, enrollment, participation information, health service utilization, billing, health status, provider information, personnel, (eligibility workers, administrative and support staff), staff training, and publications and documents.

Performance Goals for Objective 2:

(1) The Medicaid agency has re-evaluated its existing outreach activities and developed materials for wide-spread dissemination throughout the state as needed;
(2) The State will define ways to identify and enroll the State's ethnic minorities e.g., Native Americans, Asian Americans, Hispanics;
(3) It is not anticipated that the State will need to increase the number of eligibility workers initially. As of January 1, 2005, DOM assumed the responsibility of eligibility determination for MHB. The State expanded the twenty-five regional offices to thirty and deployed over four hundred Medicaid specialists to the thirty regional Medicaid offices as well as over two hundred outstationed sites, and
(4) Potentially eligible children for Medicaid and CHIP are identified through the school lunch program and Head Start.

Performance Goals for Objective 3:

By October 1, 2005, at least 65,000 CHIP enrollees will be maintained in the Program.

Performance Goal for Objective 4:

At least 85% of children enrolled in CHIP will have access to a primary care physician within 15 miles in urban/suburban areas and 25 miles in rural areas.

At least 85% of children enrolled in CHIP will have access to a hospital within 25 miles in urban/suburban areas and 45 miles in rural areas.

At least 85% of children enrolled in CHIP will have access to a pharmacy within 15 miles in urban/suburban areas and 25 miles in rural areas.

Performance Goal for Objective 5:

At least 85 % of two year olds enrolled in CHIP will have received all appropriate immunizations.

At least 85% of CHIP enrollees who were 2 to 6 years of age will have received at least one preventive or primary care visit during the year.

Performance Goals for Objective 6:

At least 90% of families responding to the member satisfaction survey will express satisfaction with customer service and provider access.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance

indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Mississippi's Management Information Retrieval System (MMIRS) provides expanded on-line, age specific utilization data that will be used in monitoring the enrollment of the established performance goals for CHIP population. In CHIP, the health plan provides encounter data to the State's Data Management Vendor (currently MEDSTAT) so that the vendor can produce required reports and provide the data to the Department of Finance and Administration for further analysis through the decision support system.

MEDSTAT is currently able to measure and track the following HEDIS performance measures for the targeted CHIP population:

(a) Well child visits in the 3rd, 4th, 5th, and 6th years of life;
(b) Use of appropriate medications for children with asthma;
(c) Children's access to primary care practitioners;
(d) Drug utilization;
(e) Inpatient utilization – general hospital/acute care;
(f) Mental health utilization; and
(g) Annual dental visits.

Objective 1:

Eligibility and enrollment are evaluated on an ongoing basis. Reports from Envision, DOM's patient information management system, on the number of applications approved, pending and denied are reviewed on a monthly basis and appropriate interventions implemented as indicated. The activities of each Medicaid specialist are monitored to determine maximum worker caseload.

Objective 2:

Through state, community, and advocacy networks, outreach activities are coordinated and evaluated. Recommendations from an internal survey and from the Outreach and Assessment and focus groups conducted by an outside consultant will be implemented as appropriate and further evaluated. Successful activities with targeted populations will be duplicated. The State will further define and refine its outreach strategies as more specific data is made available from a planned study of the uninsured children in Mississippi.

Objective 3:

Enrollment is measured by the Division of Medicaid, which provides eligibility determination services for both Medicaid and CHIP.

Objective 4:

Access is measured by the health plan using GeoAccess software applied to the CHIP

enrollment file and network provider file.

Objective 5:

Immunization rates are measured by the State Department of Health by comparing the CHIP enrollment file against the State's Immunization Registry.

Utilization of preventive and primary care services is measured through the State's decision support system supported by the MEDSTAT Group. The health plan provides encounter data to MEDSTAT, and MEDSTAT loads the data into the decision support system which provides standard reports, as well as the ability to produce ad hoc reports.

Objective 6:

Satisfaction is measured by the health plan through an annual member satisfaction survey.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☐ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☐ Well child care
- 9.3.7.3. ☐ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6. ☒ Dental care
- 9.3.7.7. ☒ Other, please list:

(a) Access to primary care

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☐ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

Again, the Medicaid agency uses the same staff as well as the Department of Finance and Administration staff to evaluate and assess CHIP quality of care-

There are reliable state-wide or comparable sub-group measures of morbidity of the Medicaid population to measure the effectiveness of the coverage of individuals enrolled in this proposed expansion.

In CHIP, the health plan submits encounter data to MEDSTAT. The decision support software supplied by MEDSTAT provides standard reports as well as enables ad hoc reporting.

9.6 ☐ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☐ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☐ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☐ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☐ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☐ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

The process of design and implementation of the CHIP was open to allow input and

participation from various interested and affected parties. Initial decisions were reached during the 1998 Legislative session in which Legislators received input from recipients, providers, advocates, business community, medical care industry, religious, and political leaders. Phase I of CHIP was set forth in statute, together with a Commission to design Phase II. This law is attached as Attachment C and the Final Report of the Commission is in Attachment G. Phase I CHIP was publicized in the routine manner through the State of Mississippi's Administrative Procedures Act. The CHIP Commission was appointed, according to state statute, to develop proposals regarding benefits, funding, and eligibility of children. The CHIP Commission meetings were open to the public, as were the meetings of the three subcommittees established to develop recommendations with respect to structure, benefits and eligibility and outreach. Public hearings were held in four locations across the state, and an advance notice of these meetings was published in both the newspaper with statewide distribution as well as local papers. In addition, the Division of Medicaid authored news releases, editorials, and public service announcements on educational television and public radio. To date, information about and the application for the State's CHIP is available on the Internet at the Division of Medicaid's web page http://www.dom.state.ms.us. The Division has established statewide coalitions not only to assist with dissemination of MHB applications and materials but also to funnel families' experiences and concerns to the Division. Finally, the Division has maintained an extensive mailing list, and all materials and updates developed are distributed ongoing to all included therein.

This application will be published in the routine manner through the State's Administrative Procedures Act.

The Health Insurance Management Board meets on the fourth Tuesday of each month. These meetings are open to the public Notification of the time and place of the meetings is sent to all persons requesting such.

A statewide coalition of state agencies, community based health/social service agencies, and local advocacy associations has been formed. CHIP is their primary focus and there have been regular meetings at which DOM, DHS, SDH, DOE, DMH and DFA are active participants. The program is enhanced by their outreach activities which complement our own, and these meetings are on-going. This coalition provides on-going feedback to the state regarding barriers, resolutions and simplifications and the outreach and enrollment process of SCHIP.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Leadership of the Mississippi Band of Choctaw Indians was contacted directly to provide input into the program development and implementation. Communication is maintained with the leadership of the Indian tribes to provide updates and input into ongoing program development and implementation and resolution of identified barriers.

As previously mentioned, a coalition of local advocacy associations has been formed. CHIP is their primary focus and there have been regular meetings at which DOM, DHS, SDH, DOE, DMH and DFA are active participants. The program is enhanced by their outreach activities which complement our own, and these meetings are on-going.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. **(Section 2107(d)) (42CFR 457.140)**

The budget must describe:

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees. The source of State funds to finance CHIP is the Health Care Expendable Trust Funds (Tobacco Funds)

SCHIP Budget Plan STATE OF MISSISSIPPI	**FFY 2004**	***FFY 2005***	***FFY 2005***	***FFY 2005***	**FFY 2006**

	Federal Fiscal Year Fourth Year Costs	Fifth Year PE Costs	Fifth Year Non-PE Costs	Federal Fiscal Year Fifth Year Costs TOTALS	Federal Fiscal Year Sixth Year Costs
Benefit Costs					
Insurance payments	117,824,291	0	132,282,082	132,282,082	154,380,000
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs	117,824,291	0	132,282,082	132,282,082	154,380,000
(Offsetting beneficiary cost sharing payments)					
Net Benefit Costs	117,824,291	0	132,282,082	132,282,082	154,380,000
Administration Costs					
Personnel and Travel	500,000		500,000	500,000	500,000
General administration	1,000,000	0	1,100,000	1,100,000	1,250,000
Contractors/Brokers (e.g., enrollment contractors)	1,250,000		1,300,000	1,300,000	1,500,000
Claims Processing	500,000		750,000	750,000	850,000
Outreach/marketing costs	100,000		50,000	50,000	75,000
Other	500,000		500,000	500,000	500,000
Total Administration Costs	3,850,000	0	4,200,000	4,200,000	4,675,000
10% Administrative Cost Ceiling	13,091,588		14,698,009	14,698,009	17,153,333
Federal Share (multiplied by enh-FMAP rate)	102,157,735	0	114,590,356	114,590,356	132,333,760
State Share	19,516,556	0	21,891,726	21,891,726	26,721,240
TOTAL PROGRAM COSTS	121,674,291	0	136,482,082	136,482,082	159,055,000

Note: PE will not be implemented in MS. **Other Costs: FY 2006 costs were estimated using 83,000 clients at $1,920 per client with administration estimated at about 3.1%.** Benefits costs are net of cost sharing. CHIP does have co-pays, but the benefits sent to the providers are net of the co-pay. DOM pays a set fee.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the

state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The State assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. **Program Integrity (Section 2101(a))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☐ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

Mississippi has established written criteria for the delivery of benefits, the determination of eligibility and for fair and equitable treatment, including the opportunity for recipients who have been adversely affected to be heard in a State administrative or appeal process. The State will administer the due process notification of adverse action relative to Title XIX. This process includes an opportunity for a fair hearing handled independently of the regional office eligibility and/or benefit decision level. Recipients may resolve any benefit decreases, terminations, or related issues through this method. All enrollees receive written information about the grievance and appeal procedures that are available to them.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

Denials related to health care services are appealed to the health plan. The final level of appeal is to an independent review entity external to the health plan. All levels of review must be completed within the required 90 day period.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each re-determination of eligibility.