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

STATE OF MISSISSIPPI

PLAN AMENDMENT
EFFECTIVE JULY 1, 1999

Revised October 28, 1999

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APPLICATION 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,

____
(Signature of Governor of State/Territory, Date Signed)

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

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 (or minutes) 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: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

The state will use funds provided under Title XXI primarily for (Check appropriate box):

1.1. ☐ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan **(Section 2103)**; **OR**

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

1.3. ☒ A combination of both of the above.

Section 2. General Background and Description of State Approach to Child Health Coverage (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 section 2110(c)(2)). 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).

Demographics

According to latest available census reports, Mississippi's population is 2,573,216.

According to latest economic studies, 25.2% of Mississippi's population is currently under 100% of the Federal Poverty Level, or approximately 643,304.

According to latest available census reports, there are 835,021 children ages less than 19 in the State of Mississippi. ***See*** Attachment A for breakdown by county.

Medicaid Eligibles

According to reports generated by the Division of Medicaid's decision support 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. ***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 Phase I

It is estimated that there are 15,000 children ages 15-19 below 100% of Federal Poverty Level in the State who will qualify for Child Health Insurance Program (CHIP) under Title XXI because they are neither eligible for Medicaid under Title XIX nor can afford creditable health care coverage through any other program i.e., State and Public School Employees' Health Insurance. During Phase I of the CHIP, Mississippi has targeted these 15,000 children for coverage under an expanded Medicaid program. To date, about 8,000 are enrolled.

CHIP Phase II

The second phase of the State's CHIP will target all children in the state below age 19 who are below 200% of the Federal Poverty Level, not eligible for Medicaid coverage, have no other creditable health coverage, and do not participate in CHIP Phase I. It is estimated there are approximately 85,000 uninsured children in the state below age 19 who are below 200% of the Federal Poverty Level and do not qualify for Medicaid or CHIP Phase I. The goal is to assess these children for eligibility for CHIP under a health coverage package that results from a public-private partnership.

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

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 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 FQHCs, 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 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 Phase I as well as the Medicaid program. The Department of Education has added a line item to its school lunch application for families to indicate an interest in CHIP, and will provide applications to be mailed or brought to DHS. All families indicating an interest will be identified to the program, for follow-up to determine eligibility for CHIP or Medicaid Push cards have been included in the annual school lunch mailout for all schools and Head Starts in the state, inviting families to apply for health benefits (Medicaid, CHIP I or CHIP II). Radio spots have aired across the state for the past several months. 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 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

This agency provides programs and services to needy and disadvantaged individuals and families through TANF, food stamps, JOBS, 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. This agency currently determines Medicaid eligibility for TANF eligibles and the State's optional poverty level categories of Medicaid eligibles. With offices in all 82 counties and 59 out stationed sites, 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

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

The Department of Education has recently added a line item to its application for the School Lunch Program for families to indicate an interest in the Child Health program. Interested families will be provided applications to be mailed or brought to DHS, and will be identified to the CHIP program for outreach and follow-up. DOE has been very cooperative in distributing CHIP materials (see page 4) and is eager to participate in CHIP outreach.

Mississippi Division of Medicaid

This agency provides a statewide system of medical assistance, health care, remedial and institutional services under Titles XIX and XVIII of the Social Security Act. In partnership with the Department of Human Services and the Department of Rehabilitation Services, the Division identifies and enrolls Medicaid eligible children. This partnership will be 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 eligible children and to uninsured children. The Division of Medicaid will work with these two agencies to continue to identify Medicaid eligible children and to begin identifying CHIP eligible children. 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 FQHCs, 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 PCP providers through its HealthMACS managed care program and its fee-for-services providers to disseminate information about eligibility for both Medicaid and CHIP for children through its Managed Care Advisory Committee and the Medical Advisory Committee.

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 unable to afford any other kind of health care coverage, the 1998 Mississippi Legislature established the Mississippi Children's Health Insurance Program Commission, which has explored the feasibility of a public-private partnership for children's health care for targeted low-income children who do not qualify for Medicaid. Phase II of the State's CHIP will involve this kind of partnership.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: **(Section 2102)(a)(3)**

Under Phase II of Mississippi's Title XXI program, coverage will be denied children who have had other creditable insurance during the six months prior to application. Creditable coverage is defined as in the Health Insurance Portability and Accountability Act (HIPAA) with the clarification that if a child is covered by creditable health insurance provided through the Indian Health Service, that child would be ineligible for CHIP, but the fact that a child may receive services from an

Indian Health Service provider would not preclude that child from being eligible for CHIP. The other exception to this rule is that children who have had Medicaid coverage within the six months prior to application, but are not eligible for Medicaid at the time of application and meet all other eligibility requirements, will be considered eligible.

For the purposes of this application, "creditable coverage" means coverage of an individual under any of the following:

(a) A group health plan, defined as an employee welfare benefit plan as defined in ERISA that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise;

(b) Health insurance coverage, defined as benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer;

(c) Part A or B of Medicare;

(d) Medicaid;

(e) Medical and dental care for members of the uniformed services or their dependents;

(f) Health insurance coverage provided through the Indian Health Service;

(g) A state health benefits risk pool;

(h) The Federal Employees Health Benefits Program; or

(i) A health insurance plan of a state, county, or other political subdivision of a state.

"Creditable coverage" does not include coverage consisting solely of excepted benefits such as coverage only for accidents, disability income insurance, liability insurance, supplemental policies to liability insurance, workers' compensation insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or limited-scope dental, vision, or long-term care insurance.

The only exceptions to the requirement that a child must not have had creditable coverage for six months are for newborns and for children who had Medicaid coverage during the six month waiting period but are not Medicaid eligible at the time of application. A newborn child for whom an application for CHIP is made within 31 days of birth will not be subject to review of creditable coverage for the six month period prior to the newborn child's date of application. Because of the higher eligibility level proposed in this application, the State does not plan to make any other exceptions to this requirement.

There will be no separate enrollment in the CHIP apart from enrollment in the Medicaid program. Outreach activities will be stepped up, as previously discussed, to enroll both Medicaid eligible and CHIP eligible children.

Based upon correspondence received from HCFA dated March 16, 1998, (refer to Attachment D) the State understands that the children of State employees who have not had creditable coverage for six months will be eligible for CHIP coverage.

The eligibility process is designed to incorporate the investigation of creditable health coverage using data matches and client interviews to ensure that only eligible, targeted low-income children are covered. Data matches will include expansion of our existing data exchanges with Blue Cross/Blue Shield, Metrahealth, Aetna, Workers' Compensation, and the Public Safety Commission. A data exchange with the State and School Employees' Health Insurance Plan will be arranged.

Section 3. General Contents of State Child Health Plan (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: **(Section 2102)(a)(4)**

Organization and Management

Coverage under Phase II CHIP, as described above, will be 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:

(a) Defining the scope and coverages 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 plans.

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.

Eligibility and Outreach

Eligibility for CHIP Phases I and II will be determined in the same manner and by the same agency as eligibility for Medicaid, the State Department of Human Services. Applications may be mailed. 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. Special mailings of these forms, with informational materials will be made at the inception of Phase II to these providers, to Headstart Programs, Tribal Nations, community action agencies, hospitals, primary care providers, pediatricians, family practitioners and schools throughout the state. Special educational and outreach materials will continue to be developed and distributed by the State for Phase I.

In Phase II the contractor will support and augment the outreach activities of the State, through such actions as developing and disseminating a provider educational/marketing package that includes a general description of how the Program works, a summary of benefits, an explanation of how to assist uninsured families with application for CHIP coverage, and a description of the importance of enrolling uninsured children. The contractor will also develop and distribute to potential members who inquire about CHIP an educational/marketing package that includes a general description of how the Program works, an explanation of the member's responsibilities, a summary of benefits, a network provider listing, and instructions on how to apply for coverage.

In addition, a line item has been added to the application for the School Lunch Program for families to indicate willingness to share income for purposes of CHIP. All families identified through this mechanism will be provided with an application or referred to the local DHS office.

The appeals process for eligibility denials for CHIP Phase II will be 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 will issue a Request for Proposals (RFP) for health insurance coverage for children eligible for Phase II CHIP. The Board will define the minimum level of benefits to be provided by the contractor (see Section 6.2) and will evaluate bids based upon the contractor's ability to provide all

services required and meet all access, quality, and contractual standards at the lowest price. The Board will select one vendor to provide marketing, enrollment, financial accounting services, and insurance coverage for the eligible population on a statewide basis. Such services will include, but not be limited to, the following:

(a) Collecting enrollment data on eligible participants;
(b) Responding to inquiries from potentially eligible families and marketing the Plan to potentially eligible populations;
(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;
(m) Conducting required data matches; and
(n) Paying and reconciling premium payments to employers, if applicable.

Vendors may propose fee for service or managed care delivery mechanisms, as long as they meet access and quality requirements. Because of the low managed care penetration in Mississippi, it is expected, that proposals will primarily address fee for service systems. It is also expected that certain managed care components will be included, such as pre-certification for inpatient admissions and selected outpatient procedures and primary care physician referrals required for specialist care.

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

Employer-Sponsored Insurance Subsidy Feature

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 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 will collect information on the levels of employer contributions available through the employer-sponsored plans that qualify for subsidy and monitor the levels of employer contributions so that if a pattern of declining contributions emerges, the level of employer contribution required can be modified to prevent crowd-out.

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 HCFA 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 CHIP 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: **(Section 2102)(a)(4)**

The contractor selected by the Health Insurance Management Board to provide insurance coverage for Phase II CHIP must provide evidence of acceptable policies and procedures for utilization and demand management. These will 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 demand management and triage. The contractor must also assure the State 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))**

4.1.1. ☒ Geographic area served by the Plan: State-wide

4.1.2. ☒ Age: birth through 18

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: Mississippi resident 30 days prior to application

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, or who had such coverage during the six months prior to their application for the program will not be eligible for CHIP

4.1.8. ☒ Duration of eligibility: 12 months from date of initial determination or until the child reaches age 19 or becomes eligible for Medicaid, whichever occurs first

4.1.9. ☐ Other standards (identify and describe): _________________________________

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))**

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))**

Eligibility for CHIP Phases I and II will be determined in the same manner and by the same agency as eligibility for Medicaid. Applications may be mailed. 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.

The State will exercise its option to provide twelve months of continuous enrollment in CHIP, except in instances where children reach the age of 19 years or become eligible for Medicaid.

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A))**

In addition to verification of information provided during the application process, the State will engage in the data exchange and matching process described in Section 2, to identify and exclude children who have had creditable coverage during the six month period prior to their application for the program.

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. **(Section 2102)(b)(3)(B))**

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Eligibility will be determined at the local offices of the Department of Human Services, by the same workers and 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. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. **(Section 2102)(b)(3)(C))**

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In addition to verification of information provided during the application process, the State will engage in the data exchange and matching process described in Section 2, to identify and exclude children who have had creditable coverage during the six month period prior to application for the program.

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). **(Section 2102)(b)(3)(D))**

Leadership of the Mississippi Band of Choctaw Indians will be contacted directly, and a targeted strategy of outreach and determination of eligibility will be developed. (Refer to Section 8.2 regarding the waiver of cost sharing requirements for American Indian/Alaskan Native children.)

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4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. **(Section 2102)(b)(3)(E))**

As discussed previously, there are no other public or private programs designed to provide creditable coverage for low-income children.

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

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

Phase I of Mississippi's Title XXI program will consist of efforts to identify and enroll children who are eligible for Medicaid and for 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 the targeted population. The State recognizes the importance of outreach to families of

children likely to be eligible for assistance under Medicaid and CHIP. To inform families of the availability of coverage and to encourage them to enroll their children, the State has done the following:

(a) Reduce barriers to participation by using the same "short form" currently used to determine eligibility for Medicaid, for CHIP; by streamlining income verification processes; dispensing with resource and asset tests for children, and by wide dissemination of applications to be mailed in;

(b) Engaged in a 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, and the Department of Rehabilitation Services regarding public awareness of these two programs;

(b) Developed for dissemination a variety of outreach strategies such as television and radio advertisements, posters, pamphlets, fliers and other promotional items;

(c) Engaged the print media as a means to educate providers;

(d) Coordinate a number of community based initiatives to educate families with potentially eligible children;

(e) Partner with entities and programs through local and state inter-agency councils, school-based health programs, including Headstart, and other community organizations whose missions include services to families and children;

(f) Outstation eligibility workers at FQHCs, Disproportionate Share Hospitals, County Health Departments, Indian reservations, and through school-based EPSDT providers; and

(g) Coordinated with the Department of Education, which mailed 400,000 push cards and added a statement and question on the 1998-99 application form for the free and reduced lunch program that asks parents for permission to share income information for purposes of the CHIP, with a place for parents to sign. This will provide a mechanism 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 and provide progress reports to advocacy groups, the Legislature, and other interested parties.

In Phase II, the State will supplement these activities by requiring the development of materials and outreach of the Contractor. The contractor will support and

augment the outreach activities of the State through such actions as developing and disseminating a provider educational/marketing package that includes a general description of how the Program works, a summary of benefits, an explanation of how to assist uninsured families with application for CHIP coverage, and a description of the importance of enrolling uninsured children. The contractor will also develop and distribute to potential members who inquire about CHIP an educational/marketing package that includes a general description of how the Program works, an explanation of the member's responsibilities, a summary of benefits, a network provider listing, and instructions on how to apply for coverage.

Special Populations

The State works regularly with the Choctaw Indians with the regular Medicaid program and the Medicaid managed care program. The State will outstation an eligibility worker at the Indian Health Facilities across the state in order to identify and enroll the children in either CHIP or Medicaid.

Teens will be reached through the Division of Medicaid's outreach contractor who will be going 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 will also identify school, church, and community teen activities that will reach teens.

The State will work 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 will 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.

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 is considering subscribing to a language service through AT&T 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 for 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 with the state as is possible.

5.2. Coordination of the administration of this program with other public and private health insurance programs : **(Section 2102(c)(2))**

Children can enroll and receive assistance in enrolling for Medicaid at Medicaid out stationed eligibility sites. For children who do not qualify for Medicaid, assistance in enrolling in CHIP will be provided.

Children with special needs who require services not covered by CHIP will be referred to the First Steps Early Intervention Program, the Children's Medical Program (CMP), or the Maternal and Child Health (Title V) Program for care coordination and "wrap around" services. This type of coordination currently exists with the State and School Employees' Health Insurance Plan for children with conditions such as hemophilia who are enrolled in the Plans and also qualify for assistance through the CMP. Providers in these programs are also eligible for reimbursement through CHIP. Referrals will be made to the Department of Vocational Rehabilitation for services not covered by CHIP but which may qualify for assistance from this Department.

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:

6.1.1. Benchmark coverage ; **(Section 2103(a)(1))**

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.)

The benefits to be provided to children under CHIP are the benefits offered under the Network Option of the State and School Employees' Health Insurance Plan plus additional benefits such as immunizations, vision and hearing screening, eyeglasses, hearing aids, preventive dental services, and routine

dental fillings. A copy of the Summary Plan Description for the State and School Employees' Health Insurance Plan is attached as Attachment F.

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))** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4)**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3))** [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))**

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))**

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.*

(1) 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. ☒ Physician services **(Section 2110(a)(3))**
Includes the following:

(1) In-hospital medical care.

(2) Medical care in the physician's office, Plan Participant'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 Plan Participant is covered under the Plan. 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 physician'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, and hearing screening, according to recommendations of the U.S. Preventive Services Task Force.*
(13) *Routine Immunizations (according to ACIP guidelines) - Vaccine will be purchased and distributed through the State Department of Health. The CHIP contractor 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 Plan Participant 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 physician services.

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**
The following drugs and medical supplies are covered:
Legend drugs (federal law requires these drugs be dispensed by prescription only)
Compounded medication of which at least one ingredient is a legend drug
Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape)
Disposable insulin needles/syringes

Growth hormones
Insulin
Lancets
Legend contraceptives
Retin-A
Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets)
Vitamin and mineral supplements, when prescribed as replacement therapy

The following are ***excluded****:*
Anabolic steroids (e.g., Winstrol, Durabolin)
Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder
Anti-wrinkle agents (e.g., Renova)
Charges for the administration or injection of any drug
Dietary supplements
Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi)
Minerals (e.g., Phoslo, Potaba)
Minoxidil (Rogaine) for the treatment of alopecia
Non-legend drugs other than those listed as covered
Pigmenting/depigmenting agents
Drugs used for cosmetic purposes
Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorrette, Nicoderm, etc)
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
Any medication not proven effective in general medical practice
Investigative drugs and drugs used other than for the FDA approved diagnosis
Drugs that do not require a written prescription
Prescription Drugs if an equivalent product is available over the counter
Refills in excess of the number specified by the physician or any refills dispensed more than one year after the date of physician'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 prepregnancy family planning 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 a Plan Participant 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 Plans' 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 Claims Administrator'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 Plan Participant'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 Plans which are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a Plan Participant to effectively carry out a physician's prescribed treatment for illness, injury, or disease, and are appropriate for use in the Plan Participant'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 physician; (3) as determined by the Plans' 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 Plans' 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 Plans' 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 physician 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 Plans' 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 be provided for nursing services in the home for illness or injury that the Plan's Utilization Review Program determines to require the skills of an RN or LPN. Benefits for nursing services provided in a participant's home must be approved by the Plan's Utilization Review Program in lieu of hospitalization. Benefits for nursing services are limited to $10,000 annually.

No nursing benefits are provided for:
(1) Services of a nurse who ordinarily lives in the Plan Participant's home or is a member of the Plan Participant'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))**
Benefits are provided for preventive dental care, as recommended by

the American Dental Association, and routine dental fillings.

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 Plan Participant is covered under the Plan. Injury to teeth as a result of chewing or biting is not considered an accidental injury.

Benefits for dental surgery are provided for the extraction of an impacted tooth.

Diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a physician or dentist is subject to a lifetime maximum benefit of $5,000 per member.

Benefits are not routinely provided for orthodontics, dentures, occlusional reconstruction, or for crowns or inlays, with the exception of the treatment of severe craniofacial anomalies or full cusp Class III malocclusions .

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 Plan'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.
(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.
(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 Plan Participant's physician and provided by a licensed physical therapist.

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

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 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:
- *(i) the participant obtains prior approval from the Plan's Utilization Review 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 Plan Participant is a suitable candidate for the transplant under the medical protocols used the Plan's Utilization Review 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 one other individual to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of one individual at the site of transplant surgery. If the Plan Participant is a minor, reasonable and necessary expenses for transportation, meals, and lodging of two other individuals is 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. Benefits provided for travel expense are charged against the recipient's Lifetime Maximum.*

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

(i) *Donor coverage includes expenses for:*

- *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 Plan participant, 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 charged against the recipient's Lifetime Maximum.*

(iii) *When both the recipient and the donor are Plan participants, benefits provided to the donor will be charged against the donor's Lifetime Maximum.*

(iv) *When the donor is a participant in the Plan, the donor is 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 Plan Participant, no benefits are payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Plan Participant's Lifetime Maximum.*

(vi) *Total benefits for solid organ or tissue transplant living donor coverage is limited to $10,000.*

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 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 Plan Participant'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))**

General 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 a Participant 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 Participant 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 Plan Participant 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 Plan Participant 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 Plan Participant while covered under the Plans 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 Claims Administrator or Plans' 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 or personal care home, except as specifically described elsewhere.*

l. *For treatment or care for obesity or weight loss 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 Plan Participants 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 Plans' 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 Plan Participants 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 Plan Participant'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 Participant by blood or marriage or who regularly resides in the Plan Participant'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 disfunction 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 Participant 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 Participant is unable to recover from the responsible party, benefits of the Plan shall be provided.*

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

6.3. **Waivers - 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 waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: **(Section 2105(c)(2) and(3))**

No waiver is requested. Although the State intends to purchase employer-sponsored insurance coverage for children who meet the defined criteria, the purchase of coverage for a spouse is not included at this time. The State acknowledges that such coverage may result incidentally from the purchase of family coverage for the children, but the State has not made the purchase of coverage for spouses an objective of this Program at this time.

6.3.1. □ **Cost Effective Alternatives.** 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:

6.3.1.1. 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))**

6.3.1.2. 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; and **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii))**

6.3.1.3. 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(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii))**

6.3.2. □ **Purchase of Family Coverage.** Describe the plan to provide 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))**

6.3.2.1. 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))**

6.3.2.2. 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))**

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))**

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 will purchase vaccine through the State Department of Health which will distribute it to providers in a manner similar to that used for the Vaccine for Children Program. The vaccine will be supplied to providers free of charge, but providers must agree to participate in the State's Immunization Registry. The contractor providing health insurance coverage for Phase II CHIP children will reimburse for the administration of the vaccine. In addition, all county health departments in the state provide childhood immunizations for a $5 administration fee, and the State Department of

Health has agreed to bill the CHIP contractor for the administration fee for all immunizations provided to CHIP children so that there will be no cost to the family.

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

In addition, when children are enrolled in CHIP through an employer-sponsored plan, the family will receive a description of the coverage provided by CHIP, including the following information:

(a) Explanation that there is no cost sharing required under CHIP except for the minimal co-payments for families over 150% of FPL;
(b) Statement that there is no cost sharing for American Indian/Alaska Native children;
(c) Explanation that because most providers will file both primary and secondary claims and the family need only provide the information necessary for completing the claims, the child may be able to receive immunizations from his/her private physician at no cost to the family;
(d) Description of the procedures that should be followed to file a secondary claim for coverage of deductibles, co-insurance, and co-payments in the event that a provider does not file for them; and
(e) Explanation that well child care and immunizations are available through the local county health department clinics at no cost to CHIP eligible families.

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

For Phase II CHIP the contractor will be required to provide evidence of a suitable credentialing process for participating providers.

7.1.2. ☐ Performance measurement

7.1.3. ☒ Information strategies

The contractor will be required to submit 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 reports, as well as allows the development of ad hoc reports using the MEDSTAT system.

7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services , including emergency services. (**2102(a)(7)(B))**

The contractor will be required to meet certain access standards in order to be awarded the contract for the Children's Health Insurance Program. These access standards will 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 State will require the contractor 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."

The contractor will be required to conduct a member satisfaction survey at least annually. This survey will include questions related to access to health care services.

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?

8.1.1. ☒ YES.
8.1.2. NO**, skip to question 8.5.**

8.2. Describe the amount of cost-sharing and any sliding scale based on income:

(Section 2103(e)(1)(A))

8.2.1. Premiums: None
8.2.2. Deductibles: None
8.2.3. Coinsurance: None
8.2.4. Other: Co-payments as outlined in the following table

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

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 and eyeglasses, and hearing aids.

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

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: The member handbook and ID card provided to each enrollee will outline cost sharing requirements.

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of 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))**

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

8.4.3. ☒ No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4))**

8.4.5. ☒ No premiums or cost-sharing will be used toward state matching requirements. **(Section 2105(c)(5)**

8.4.6. ☒ 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))

8.4.7. ☒ 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))**

8.4.8. ☒ 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))**

8.4.9. ☒ 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))**

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 annual income for the year involved: **(Section 2103(e)(3)(B))**

The Health Plan providing coverage under Phase II will track 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. The state assures that, with respect to pre-existing medical conditions , one of the following two statements applies to its plan:

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

8.6.2. ☐ 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 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2109(a)(1),(2))**. Please describe:

Section 9. Strategic Objectives and Performance Goals for the 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))**

1. The infrastructures of the Mississippi Department of Human Services and the Mississippi Medicaid agency will be able to accommodate all critical facets of Phase I of Mississippi's Title XXI program. (Phase I is defined as expanding Medicaid program eligibility to uninsured children who are less than 19 years of age, born on or before September 30, 1983, and who have incomes equal to or less than 100% of the Federal Poverty Level.)

2. In Phase II, the Contractor will complement the existing infrastructure with expanded outreach, interface with state and local agencies, providers, schools, etc. The Contractor will refer potential eligibles to the Department of Human Services for determination of eligibility and enroll those not eligible for Medicaid, with incomes below 200% of poverty.

3. Previously uninsured children who will potentially be eligible for Mississippi's Title XXI program will be identified through ongoing outreach activities.

4. Low income children who were previously without health insurance coverage will have health insurance coverage through Mississippi's Title XXI program.

5. Children enrolled in Mississippi's Title XXI program will have a primary care physician.

6. Mississippi's Title XXI program will improve the health status of children enrolled in the program as well as improve access to the health care system.

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

Performance Goal for Objective 1:

By July 1, 1998, the capacity within the Mississippi Medicaid Agency and the

Mississippi Department of Human Services was appropriately expanded or modified to meet the target of enrolling approximately 15,000 children in year one of Mississippi's Phase I CHIP. These areas will 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 develop materials for wide-spread dissemination throughout the state. (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. (4) In Phase II, the Contractor will provide supplemental education and outreach, to targeted providers and community agencies. In addition, potential eligibles for Medicaid and CHIP will be identified through the school lunch program.

Performance Goals for Objective 3:

By July 1, 1999, 10,000 previously uninsured low-income children have health insurance coverage at 100% FPL. By July 1, 2000, 35,000 children will be assessed for Phase II chip eligibility and 30,000 will be enrolled. The 30,000 Medicaid children lost during TANF roll-over since 1996 will be recaptured.

Performance Goal for Objective 4:

By July 1, 1999, those children at 100% FPL enrolled in Mississippi's Title XXI program will have a medical home. By July 1, 2000, at least 60% of children enrolled in Phase II CHIP will have access to a primary care physician within 15 miles of their residence in urban/suburban areas or 25 miles in rural areas.

Performance Goal for Objective 5:

The Medicaid program's measures of health status and quality of care will be applied to the new population in CHIP.

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))

MEDSTAT, the Data Management Vendor for the Division of Medicaid and the Department of Finance and Administration, is currently running HEDIS 3.0 measures for the capitated managed care HMO pilot project, fee for service, and PCP HealthMACS populations, as well as the State and School Employees' Health Insurance Plan. The application of these measures will be expanded to the targeted CHIP population. In addition, Mississippi's Management Information Retrieval System (MMIRS) will be able to provide expanded on-line, age specific utilization data that will be used in monitoring the progress of the established performance goals for the targeted Phase I CHIP population. In Phase II of CHIP, the Contractor will be required to provide 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.

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

(a) Well-care visits - children who had at least one comprehensive well-care visit with a primary care provider.
(b) Inpatient Utilization - General Hospital/Acute Care - utilization of acute inpatient services in medicine, surgery and maternity.
(c) Ambulatory Care - utilization of ambulatory services: outpatient visits, emergency room visits, and ambulatory surgery/procedures.
(d) Discharge and Average Length of Stay - Maternity Care - utilization information on maternity-related care for enrolled females who had live births.
(e) Outpatient Drug Utilization - outpatient drug utilization of drug prescriptions.
(f) Teenage pregnancies and prenatal care for teenagers; high risk teenage pregnancies.

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. (Refer to discussion in Section 9.3.)

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) Well-care visits - children who had at least one comprehensive well-care visit with a primary care provider.
(b) Inpatient Utilization - General Hospital/Acute Care - utilization of acute inpatient services in medicine, surgery and maternity.
(c) Ambulatory Care - utilization of ambulatory services: outpatient visits, emergency room visits, and ambulatory surgery/procedures.
(d) Discharge and Average Length of Stay - Maternity Care - utilization information on maternity-related care for enrolled females who had live births.
(e) Outpatient Drug Utilization - outpatient drug utilization of drug prescriptions.
(f) Teenage pregnancies and prenatal care for teenagers; high risk teenage pregnancies.

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))**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)**

The State has an approved Section 1915(b) waiver for primary care and case management using primary care physicians (PCP). This program ,

HealthMACS, is responsible for assessment and evaluation under the PCP waiver and the Medicaid agency intends to use the same staff as well as the Quality Management Division staff to evaluate and assess PHASE I CHIP quality of care using the same tool, HEDIS. In addition, the Medicaid agency's EPSDT staff and reports will be used to monitor and assess compliance with the periodicity requirements for preventive care measures and immunizations.

The State also has a pilot Medicaid capitated managed care program in six counties. Enrollment into these HMOs will also be an option available to the children under PHASE I CHIP. Again, the Medicaid agency intends to use the same staff as well as the Quality Management Division staff to evaluate and assess CHIP quality of care in the HMOs using the same tool, HEDIS, as well as the Medicaid agency's EPSDT staff and reports will be used to monitor and assess compliance with the periodicity requirements for preventive care measures and immunizations.

Finally, the Medicaid agency will use its decision support systems, MMIRS and Codman, to verify appropriate utilization of medical services for the PHASE I CHIP population in the fee-for-service, PCP managed care, and capitated managed care programs.

There are no reliable state-wide or comparable sub-group measures of morbidity except the Medicaid population to measure the effectiveness of the coverage of individuals enrolled in this proposed expansion.

In Phase II CHIP, the contractor will be required to submit encounter data to MEDSTAT. Appropriate HEDIS measures will be assessed. As described previously, the same decision support software will be used in CHIP as is currently used by the State and School Employees' Health Plan. As a result, the Department of Finance and Administration will be able to use State and Public School Employee data for comparisons to assess performance within CHIP.

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))**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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))**

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 1115 (relating to waiver authority)

9.8.5. ☒ Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

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

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

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

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

9.8.10. ☒ 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))**

The process of design and implementation of the CHIP has been an open one. 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 has been 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 advance notice of these 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. Information about the State's CHIP is available on the Internet at the Division of Medicaid's web page http://www.dom.state.ms.us. Finally, the Division has maintained an extensive mailing list, and all materials developed or received by the CHIP Commission have been distributed 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 a monthly basis on the fourth Tuesday of each month. These meetings are open to the public and incorporate an opportunity for public comment whenever requested. Meetings of the CHIP Advisory Board and Committee are also open to the public. Notification of the time and place of the meetings is sent to all persons requesting such.

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.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. **(Section 2107(d))**

PHASE I

FFY 1998	
1. Benefit expenditure (Medicaid expansion)	$ 10,125,000
2. Administrative	1,125,000
Total Expenditures	$ 11,250,000
3. Federal Share 83.96%	$ 9,445,500
4. State Share	1,804,500
Total Funding	$ 11,250,000

FFY 1999	
1. Benefit expenditure (Medicaid expansion)	$6,750,000
2. Administrative	750,000
Total Expenditures	$7,500,000

3. Federal Share 83.75%	$ 6,281,250
4. State Share	1,218,750
	$ 7,500,000

FFY 2000

1. Benefit expenditure (Medicaid expansion)	$ 3,375,000
2. Administrative	375,000
Total Expenditures	$ 3,750,000
3. Federal Share 83.76%	$ 3,141,000
4. State Share	609,000
	$ 3,750,000

PHASE II

FFY 1999

1. Benefit expenditure	$ 10,800,000
2. Administrative	1,200,000
Total Expenditures	$ 12,000,000
3. Federal Share 83.75%	$ 10,050,000
4. State Share	1,950,000
Total Funding	$ 12,000,000

FFY 2000

1. Benefit expenditure	$ 45,000,000
2. Administrative	4,000,000
Total Expenditures	$ 49,000,000
3. Federal Share 83.76%	$ 41,042,400
4. State Share	7,957,600
Total Funding	$ 49,000,000

FFY 2001

1. Benefit expenditure	$ 90,000,000
2. Administrative	6,000,000
Total Expenditures	$ 96,000,000
3. Federal Share 83.76%	$ 80,409,600
4. State Share	15,590,400

Total Funding $ 96,000,000

The above planned expenditures and revenues are described below:

Expenditures

1. Benefit expenditures

   This line item reflects the reimbursement to providers for the provision of health care services to the CHIP enrollees. All expenditures will be in accordance with Medicaid reimbursement policies.

2. Administrative expenditures
   This line item reflects the cost of expanding the infrastructures of the Mississippi Department of Human Services and the Mississippi Division of Medicaid to accommodate Phase I of CHIP. This expansion includes hiring new Medicaid eligibility workers and out stationed workers; conducting expanded outreach activities; hiring new staff for provider educational services; conducting provider workshops; printing documents, brochures, manuals, and public service pieces; additional mail expenses for disseminating enrollment information. Additional expenditures include some systems modifications, more recipient identification cards, and additional claims processing.

This line item reflects the maximum amount that will be spent on administrative expenses given the limitations of administrative costs under Title XXI.

Revenues

3. Federal share

   This line item reflects a portion of the funds which have been allocated to Mississippi under Title XXI.

4. State share

   This line item reflects a portion of funds which have been allocated specifically for CHIP to the Mississippi Division of Medicaid from the Mississippi Legislature's General Funds.

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))**

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

10.1.2. ☒ Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.
Mississippi will utilize this chart when submitting its first annual report.

Attributes of Population	Number of Children with Creditable Coverage XIX	 OTHER CHIP	Number of Children without Creditable Coverage	**TOTAL**
Income Level:				
< 100%				
≤ 133%				
≤ 185%				
≤ 200%				
> 200%				
Age				
0 - 1				
1 - 5				
6 - 12				
13 - 18				
Race and Ethnicity				
American Indian or Alaskan Native				
Asian or Pacific Islander				
Black, not of Hispanic origin				
Hispanic				
White, not of Hispanic origin				
Location				
MSA				
Non-MSA				

10.2. ☒ State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**

10.2.1. ☒ An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. ☒ The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2. ☒ The quality of health coverage provided including the types of benefits provided;

10.2.2.3. ☒ The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4. ☒ The service area of the state plan;

10.2.2.5. ☒ The time limits for coverage of a child under the state plan;

10.2.2.6. ☒ The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7. ☒ The sources of non-Federal funding used in the state plan.

10.2.3. ☒ An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

10.2.4. ☒ A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

10.2.5. ☒ An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.

10.2.6. ☒ A description of any plans the state has for improving the availability of health insurance and health care for children.

10.2.7. ☒ Recommendations for improving the program under this Title.

10.2.8. ☒ Any other matters the state and the Secretary consider appropriate.

10.3. ☒ The state assures it will comply with future reporting requirements as they are

developed.

10.4. ☒ 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.

ATTACHMENTS

Attachment A

Breakdown of state population of children under age 19 and Unserved Medicaid Eligibles by county

Attachment B

Breakdown of Medicaid Enrolled Children under age 21 by County

Attachment C

HCFA letter dated March 16, 1998, regarding eligibility of children of State employees

Attachment D

Mississippi Code Ann. Section 25-15-303

Attachment E

Checklist of Benchmark Plan Benefits

Attachment F

1999 Summary Plan Description for the State and School Employees Insurance Plan

Attachment G

Mississippi Children's Health Care Act - Mississippi Code Ann. Section 41-86-1 et seq.

Attachment H

Final report of the Children's Health Insurance Program Commission (without attachments)

ATTACHMENT A

ATTACHMENT B

ATTACHMENT C

ATTACHMENT D

ATTACHMENT E

ATTACHMENT F

ATTACHMENT G

ATTACHMENT H