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State/Territory Name: Mississippi

State Plan Amendments (SPA) #: MS-CHIPSPA#;

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Final Approved State Plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

APR 17 2015

Dr. David J. Dzielak
Executive Director
Division of Medicaid
Walter Sillers Bldg.
550 High Street, Suite 1000
Jackson, MS 39201

Dear Dr. Dzielak:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number 9, submitted on February 9, 2015, has been approved. The SPA has an effective date of January 1, 2015.

Through this SPA, Mississippi transitions administration of the separate CHIP benefit package from one to two Coordinated Care Organizations (CCOs) and raises the annual limit on dental benefits from \$1,500 to \$2,000.

Your title XXI project officer is Ms. Cassandra Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
Facsimile: (410) 786-5943
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

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If you have additional questions, please contact Ms. Kelly Whitener, Director, Division of State Coverage Programs at (410) 786-0719.

We look forward to continuing to work with you and your staff.

Sincerely,



Eliot Fishman *[Handwritten Signature]*

Director

cc: Jackie Glaze, ARA, CMS Region IV

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

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

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

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

/s/
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: David J. Dzielak, Ph.D.	Position/Title: Executive Director, MS Div. of Medicaid
Name: Janis Bond	Position/Title: Deputy Administrator, Office of Enrollment
Name: Margaret King	Position/Title: Deputy Administrator, Office of Finance

***Disclosure. 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 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

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

2101)(a)(1)); (42 CFR § 457.70):

1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

1.1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

1.1.3. A combination of both of the above. (Section 2101(a)(2))

1.1-DS The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

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

1.3 Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR § 457.130)**1.4** Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR § 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan: Effective Date: July 1, 1998

Implementation Date: July 1, 1998

Amendment #1 submitted: August 1, 1998	Implemented January 1, 2000
Amendment #2 submitted: September 22, 1999	Implemented January 1, 2000
Amendment #3 submitted: July 6, 2000	Implemented October 1, 2000
Amendment #4 submitted: July 3, 2001	Implemented July 1, 2001
Amendment #5 submitted: September 30, 2002	Implemented January 1, 2005
Amendment #6 submitted: December 29, 2005	Implemented January 1, 2005
Amendment #7 submitted: December 6, 2010	Implemented January 1, 2010

Mental health parity requirements.

Amendment #8 submitted: September 25, 2013 Implemented July 1, 2013
Transition of the management of the Children’s Health Insurance Program (CHIP) in Mississippi for the oversight of the separate health plan to the Mississippi Division of Medicaid; inclusion of covered dental benefits required by the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA); clarification of enrollee coverage provided in an emergency department.

Amendment #9 submitted: February 9, 2015 Implemented January 1, 2015
To reflect the change in operation of the separate CHIP health plan to two (2) contracted MCOs.

1.4- TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

TN No. 8: Approval Date July 10, 2014

Effective Date 07/01/2013

CHIP State Plan Amendment (SPA) #8 was submitted to the Mississippi Band of Choctaw Indians, the one federally recognized tribe in the state, on January 4, 2013, for review and comment. Specifically, the material for SPA #8 was sent to the Director of Financial Services for the Mississippi Band of Choctaw Indians and to the Office of Attorney General, Mississippi Band of Choctaw Indians. This was in accordance with Mississippi's tribal consultation process that includes notifying the tribal designees in writing at least sixty (60) days prior to each formal submission of Medicaid or CHIP SPAs or other proposals that would have a direct impact on Indian health programs. Tribal designees had previously been verbally informed about the upcoming transition of the administration of CHIP to the Mississippi Division of Medicaid in an in-person meeting that occurred on October 15, 2012, between tribal staff and Medicaid program staff, which was held to discuss other SPA-related proposals. There was no formal response by tribal officials to the submission of the SPA #8 changes submitted for their review on January 4, 2013.

The Mississippi Band of Choctaw Indians was notified on October 29, 2013, that the effective date was changed to July 1, 2013, instead of January 1, 2013.

TN No. 9: Approval Date April 17, 2015

Effective Date 01/01/2015

Tribal Notification: A conference call was held with the Mississippi Band of Choctaw Indians on September 16, 2014, to discuss the proposed changes to CHIP to be effective 01/01/2015, and of the name change of the SPA to CHIP #9. The CHIP SPA #9 draft SPA pages were then submitted to the Mississippi Band of Choctaw Indians, the one federally recognized tribe in the state, on September 19, 2014, for review and comment. Specifically, the material for SPA #9 was sent to the Deputy Health Director for the Mississippi Band of Choctaw Indians and to the Office of Attorney General, Mississippi Band of Choctaw Indians. This is in accordance with Mississippi's tribal consultation process that includes notifying the tribal designees in writing at least sixty (60) days prior to each formal submission of Medicaid or CHIP SPAs or other proposals that would have a direct impact on Indian health programs. There was no formal response by tribal officials to submission of the CHIP SPA #9 changes submitted for their review on September 19, 2014.

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

- 2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR § 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR § 457.80(a))**

Demographics

According to the latest available census reports, Mississippi's population is 2,967,297 (2010 Census).

According to the U.S. Census Bureau, 22.3% of Mississippi's population is currently under 100% of the Federal Poverty Level (FPL).

30% of the families in Mississippi have children under the age of 18.

According to the 2010 Census reports, there are 849,495 (28.6%) children less than 19 years of age in the State of Mississippi.

Medicaid Eligibles

According to 2014 Medicaid Management Information Systems (MMIS) reports generated by the Mississippi Division of Medicaid, there are 362,288 Mississippi children less than 19 years of age currently enrolled in Medicaid.

CHIP

Mississippi originally implemented CHIP in July 1998 with a Medicaid expansion program for children 15 to 18 years of age at 100% of the FPL. This phase of the program ended as of October 01, 2002. To date, the State's CHIP targets all children in the state below age 19 who are below 200% FPL, not eligible for Medicaid coverage, and have no other health coverage. According to the Census Bureau's 2013 American Community Survey, there are 44,000 uninsured children in Mississippi less than 19 years of age and below 200% FPL who are not covered by Medicaid or CHIP. The goal is to assess these children for CHIP eligibility under a health coverage package. As of August 2014, 70,973 children were enrolled in CHIP.

- 2.2. Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at 42 CFR § 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR § 457.10)**

N/A

- 2.3-TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)) ; (ARRA #2,**

CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

The Mississippi Division of Medicaid consults with the tribe by notifying the Mississippi Band of Choctaw Indians designee, in writing, with a description of the proposed changes and direct impact, at least sixty (60) days prior to each submission by the State of any Medicaid SPA, waiver proposals, waiver extensions, waiver amendments, waiver renewals, and proposals for demonstration projects that are likely to have a direct effect on Indians, Indian Health programs, or Urban Indian Organizations (I/T/U) by email. The Director of Financial Services is the Mississippi Band of Choctaw Indians designee. Direct impact is defined as any Medicaid or CHIP program changes that are more restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to Indian Health Programs, Tribal Organizations, or Urban Indian Organization providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact I/T/U providers. If no response is received from the tribe within thirty (30) days, the Mississippi Division of Medicaid will proceed with the submission to the Centers for Medicare and Medicaid Services (CMS).

If the Mississippi Division of Medicaid is not able to consult with the tribe sixty (60) days prior to a submission, a copy of the proposed submission along with the reason for the urgency will be forwarded to the tribe designee. A conference call with the designee and/or other tribal representatives will be requested to review the submission and its impact on the tribe. The Mississippi Division of Medicaid will then confirm the discussion via email and request a response from the designee to ensure agreement on the submission. This documentation will be provided as part of the submission information to CMS.

The tribe's Director of Financial Services, Donita Stephens, was notified by e-mail on January 10, 2013, of the proposed CHIP #8 submission.

While not required, the Mississippi Division of Medicaid is planning quarterly meetings with the tribe to discuss proposed Medicaid and CHIP program changes and other topics as permitted by

schedules. In person meetings with the tribe have been held on July 10, 2012, October 15, 2012, March 8, 2013, and June 18, 2013. A meeting regarding CHIP and other issues was held on October 14, 2014 and December 15, 2014.

Section 3. Methods of Delivery and Utilization Controls

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

Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

Organization and Management

The Mississippi Division of Medicaid will select two (2) Coordinated Care Organizations (CCO) through a competitive bid process for the administration of the State's separate CHIP. The Mississippi Division of Medicaid will be responsible for administration, management, and oversight of the CCOs.

Management of Coverage

The Mississippi Division of Medicaid will select two (2) CCOs through a competitive bid process for the administration of the State's separate CHIP. The Mississippi Division of Medicaid defines the minimum level of benefits to be provided by the CCOs (see Section 6.2). The CCOs are required to provide enrollment, financial accounting services, and insurance coverage for the eligible population on a statewide basis. Such services include, but are not limited to, the following:

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

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

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

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

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

Section 4. Eligibility Standards and Methodology

4.0. Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group:

4.1. **Separate Program** Check all standards that will apply to the State plan. (42 CFR § 457.305(a) and 457.320(a))

4.1.0 Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

Social Security Administration (SSA) verification is the primary source used to verify citizenship for applying children. If citizenship cannot be successfully verified by SSA, documentation is requested for applying children. A 90-day reasonable opportunity period is granted to provide documentation, during which time benefits are granted if otherwise eligible.

4.1.1 Geographic area served by the Plan if less than Statewide:

4.1.2 Ages of each eligibility group, including unborn children and pregnant women (if

applicable) and the income standard for that group:

Birth to age 1 – 194% FPL to 209% FPL.

Age 1 to age 6 – 133% FPL to 209% FPL.

Age 6 to age 19 – 133% FPL to 209% FPL.

4.1.2.1-PC Age: _____ through birth (SHO #02-004, issued November 12, 2002)

4.1.3 Income of each separate eligibility group (if applicable):

4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through _____% of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 Residency (so long as residency requirement is not based on length of time in state):

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 with coverage under other creditable health coverage at the time of application and children who are eligible for Medicaid are not eligible for CHIP.

4.1.8 Duration of eligibility, not to exceed twelve (12) months:

Twelve (12) months from the effective date of coverage for CHIP or until the child reaches 19 years of age or otherwise loses protected eligibility under the continuous eligibility provision.

4.1.9 Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

4.1.9.1 States should specify whether Social Security Numbers (SSN) are required.

4.1.9.2 Continuous eligibility

All CHIP and Medicaid children are granted twelve (12) continuous months of eligibility unless the child reaches age 19 or otherwise loses protected eligibility under the continuous eligibility provision.

4.1-PW Pregnant Women Option (section 2112) The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the

population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

4.1- LR

Lawfully Residing Option (Sections 2107(e)(1)(J) and 1993(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
 - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana

- Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
 Elected for children under age _____.

4.1.1-LR The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS Supplemental Dental (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. Assurances The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR § 457.320(b))

- 4.2.1.** These standards do not discriminate on the basis of diagnosis.
4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.
4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR § 457.320(b))

4.2.1-DS These standards do not discriminate on the basis of diagnosis.

4.2.2-DS 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-DS These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42 CFR §, 457.350)

Eligibility for CHIP is determined in the same manner and by the same agency and staff as eligibility for Medicaid. Effective January 1, 2014, the State utilizes an alternative single, streamlined application developed by the State in accordance with section 1413(b)(1)(B) of the Patient Protection and Affordable Care Act (PPACA), as amended, and approved by the Secretary. These applications are available at community health centers, Head Start, health department clinics, other providers of care, the local DHS offices, the Mississippi Division of Medicaid website, and may be submitted via the internet website described in 42 CFR § 435.1200(f), by telephone, via mail, in person, via fax, and via email.

The State provides twelve (12) months of continuous enrollment in CHIP until the child reaches age 19 or otherwise loses protected eligibility under the continuous eligibility provision. Renewal will be conducted via administrative review based on available electronic sources. If determination is not possible based on available sources, a pre-populated renewal form will be issued to the Member.

4.3.1 Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(4)) (42 CFR §, 457.305(b))

Check here if this section does not apply to your State.

4.3.2. Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR § 457.355)

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

4.4 Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

4.4.1. Only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan.(Sections 2102)(b)(3)(A), 2110(b)(2)(B)) (42 CFR § 457.310(b), 42 CFR § 457.350(a)(1) and 42 CFR § 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women. Mississippi does not impose a waiting period for enrollment in CHIP. Enrollment in CHIP is possible in the month following the month coverage terminates from other creditable coverage.

4.4.2. Children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102)(b)(3)(B)) (42 CFR §, 457.350(a)(2)) Each child is screened for Medicaid eligibility first and if determined ineligible and the child is uninsured, is evaluated for CHIP enrollment.

4.4.3. Children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR § 431.636(b)(4))

Children are screened for Medicaid eligibility first and if determined ineligible (and otherwise uninsured), are evaluated for CHIP enrollment.

4.4.4. The insurance provided under the State child health plan does not substitute for coverage under group health plans; states should check the appropriate box. (Section 2102)(b)(3)(C)) (42 CFR § 457.805) (42 CFR § 457.810(a)-(c))

An applying child's current insurance status is self-reported at the time of application and annual review. If the CHIP CCOs discover that a claim submitted lists any other insurance coverage for an eligible CHIP child, the CCOs provide this information to the

Mississippi State Office of the Division of Medicaid for further investigation. Pending the findings, CHIP eligibility may or may not be terminated.

4.4.4.1. (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined.

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

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR § 457.350(a) and 42 CFR § 457.80(c). Describe this process.

The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42 CFR § 457.80(b))

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

Medicaid and CHIP are the only public health insurance programs 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 federally qualified health centers (FQHC), newly-funded school health nurses, and several Indian Health Service Clinics. In

addition, CHIP provides specialty care to uninsured and Medicaid enrolled children with special health care needs. The Department of Mental Health (DMH) provides mental health services to children through their Community Mental Health Clinics on a sliding scale fee arrangement based upon the patient's declared income. Program information presentations are provided on an on-going basis to schools and Head Start programs in the state, inviting families to apply for health benefits (Medicaid or CHIP). Applications, pamphlets, flyers, and posters are widely distributed.

Mississippi State Department of Health (MSDH)

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

Mississippi Department of Human Services (DHS)

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

Department of Rehabilitation Services (DRS)

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

Department of Mental Health (DMH)

This agency provides all services in the state for the mentally ill, emotionally disturbed, alcoholic, drug dependent and intellectually/developmentally disabled persons. These services are provided through a system of Community Mental Health Centers in eight regions of the state, several ICF-ID/DDs, 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.

Mississippi Division of Medicaid (DOM)

The Mississippi Division of Medicaid provides a statewide system of medical assistance, health care, and remedial and institutional services under Titles XXI, XIX, and XVIII of the Social Security Act. In partnership with DHS, MSDH, and DMH, the Mississippi Division of Medicaid identifies and enrolls Medicaid eligible children. This partnership has been maintained and strengthened to identify and enroll CHIP eligible children. MSDH and DMH serve as providers of services to Medicaid/CHIP eligible children and to uninsured children. The Mississippi Division of Medicaid works with these agencies and a statewide coalition of other partners to identify, enroll, and retain eligible children for the Mississippi Health Benefits Program (Medicaid and CHIP). In addition, the Mississippi 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, disproportionate share hospitals (DSH) and MSDH Clinics, the Medicaid agency will utilize these service providers to identify Medicaid and CHIP eligible children. The Medicaid agency will increase its reliance on primary care providers (PCP) through its fee-for-services providers to disseminate information about eligibility for both Medicaid and CHIP for children through its Medical Advisory Committee.

- 5.1.2.** (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

N/A

- 5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. Section 2102(a)(3) and 2102(c)(2) and 2102(b)(3)(E))(42 CFR § 457.80(c)). This item requires a brief overview of how Title XXI efforts -- particularly new enrollment outreach efforts will be coordinated with and improve upon existing State efforts described in Section 5.2.**

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

- 5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.**

N/A

5.3 Strategies

Outreach

Medicaid and CHIP applications and information are distributed statewide through health care providers and a statewide coalition of collaborative partners. Through these providers and collaborative partners, families are informed of the availability of coverage under Titles XIX and XXI. Outreach activities consist of efforts to identify and enroll children who are eligible for both Medicaid and CHIP. As previously discussed, Medicaid and CHIP are the only public health insurance programs for children in the state, and there is currently no private health coverage for children who cannot afford to pay for it. Thus, Medicaid and CHIP enrollment represent the only viable public alternatives for the State's children to have creditable insurance coverage in this targeted population. The State recognizes the importance of outreach to families of children likely to be eligible for assistance and to encourage them to enroll and retain their children, the State has done the following:

- (a) Reduced barriers to participation by using the alternative single, streamlined application as described in PPACA.
- (b) Engaged in provider education efforts because providers are a vital link to this population;
- (c) Initiated cooperative efforts with MSDH , DHS, DMH, and DRS regarding public awareness of these two programs;
- (d) Developed statewide coalitions to assist with the dissemination of materials and conducting a variety of outreach strategies such as health fairs and forums, development of informational fliers, posters, and other promotional items;
- (e) Engaged the print and radio media as a means to educate providers;
- (f) Coordinated a number of community based initiatives to educate families with potentially eligible children;
- (g) Partnered with entities and programs through local and state inter-agency councils, school-based health programs, and other community organizations whose missions include services to families and children; and
- (h) Out-stationed Medicaid specialists at FQHCs, Disproportionate Share Hospitals, County Health Departments, Indian reservations, and through school-based EPSDT providers. Beyond administering outreach, the State will ensure that staff at the appropriate state agencies will be well-trained to respond to inquiries from the public and provide progress reports to advocacy groups, the Legislature, and other interested parties.

Special Populations

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

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

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

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

The State has targeted two areas of limited English proficiency: Spanish speaking families in the Southern part of the state and Vietnamese speaking families throughout the state. The State has subscribed to a language line service to help with on-site screening and enrollment processes. The Mississippi Division of Medicaid's website is available in multiple languages.

The State works closely with children's advocacy groups to define and find solutions to various barriers to enrollment in health programs for children, including Medicaid and CHIP.

Section 6. Coverage Requirements for Children's Health Insurance

- 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 proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42 CFR § 457.410(a))

- 6.1.1.** Benchmark coverage; (Section 2103(a)(1) and 42 CFR § 457.420)
- 6.1.1.1.** FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR § 457.420(a)) (If checked, attach copy of the plan.)
- 6.1.1.2.** State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3.** HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.2.** Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR § 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any

exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR § 457.431.

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

6.1.4. Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR § 457.450)

6.1.4.1. Coverage the same as Medicaid State plan

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

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

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

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

6.1.4.7. Other (Describe)

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

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

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

- (1) Hospital room and board (including dietary and general nursing services).
- (2) Use of operating or treatment rooms.
- (3) Anesthetics and their administration.
- (4) Intravenous injections and solutions.
- (5) Physical therapy.
- (6) Radiation therapy.
- (7) Oxygen services and inhalation therapy

- (8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms.
- (9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs.
- (10) Dressings and Supplies, sterile trays, casts, and orthopedic splints.
- (11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.
- (12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations.
- (13) Intensive, Coronary, and Burn Care Unit services.
- (14) Occupational therapy.
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))

Include the following:

- (1) In-hospital medical care.
- (2) Medical care in the physician's office, enrollee's home, or elsewhere.
- (3) Surgery.
- (4) Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the program. Injury to teeth as a result of chewing or biting is not considered an Accidental Injury. Covered medical expense must be incurred as a direct result of an accidental injury to natural teeth and medical treatment must begin within ten (10) days of the accidental injury.
- (5) Administration of anesthesia.
- (6) Diagnostic services, such as clinical laboratory examinations, x-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests.
- (7) Radiation therapy.
- (8) Consultations.
- (9) Psychiatric and psychological service for nervous and mental conditions.
- (10) Physicians assisting in surgery, where appropriate.
- (11) Emergency care or surgical services rendered in a practitioner's office including but not limited to surgical and medical supplies, dressings, casts, anesthetic, tetanus, serum, and x-rays.
- (12) Well child assessments, including vision screening, laboratory tests and hearing screening, according to recommendations of the U.S. Preventive Service Task Force. Vision and hearing screening are to be included as part of the periodic well child assessments.
- (13) Routine immunizations (according to Advisory Committee on Immunization

Practices (ACIP) guidelines)-Vaccine is purchased and distributed through MSDH. The CCO will reimburse providers for the administration of the vaccine.

Exclusions and limitations include: the CCOs may require prior authorization and physician's prescription and/or order for outpatient services.

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

Certain surgeries must be pre-certified as medically necessary.

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

- (1) Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure.
- (2) Pre-operative preparation.
- (3) Use of facility (operating rooms, recovery rooms, and all surgical equipment).
- (4) Anesthesia, drugs and surgical Supplies.

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

Covered as medical services (refer to 6.2.3.).

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

Prior authorization is required for selected drugs. A preferred drugs list will be implemented with provisions for medically necessary exceptions.

The following drugs and medical supplies, if medically necessary, U.S. Food and Drug Administration (FDA) approved, non-experimental drugs prescribed by a licensed practitioner, and prescribed for the medical treatment of illness and/or injuries, are covered:

- (1) Legend drugs.
- (2) Compounded medication of which at least one ingredient is a legend drug.
- (3) Disposable diabetic supplies, including, but not limited to, insulin needles/syringes, blood/urine glucose/acetone testing agents.
- (4) Insulin.
- (5) Fluoride supplements.

The following are excluded:

- (1) Anabolic steroids.
- (2) Drugs when used for weight loss.
- (3) Charges for the administration or injection of any drug.
- (4) Drugs when used to promote fertility.
- (5) Over-the-counter (OTC) items except those specifically listed as covered.

- (6) Drugs used for cosmetic purposes or hair growth, including, but not limited to anti-wrinkle agents, drugs used to treat alopecia, and pigmenting/depigmenting agents.
- (7) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered.
- (8) Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature.
- (9) Drugs that are investigational or approved drugs used for investigational purposes.
- (10) Refills in excess of the number specified by the practitioner or any refills dispensed more than one (1) year after the date of practitioner's original prescription.

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

6.2.8. Laboratory and radiological services (Section 2110(a)(8))

Certain diagnostic tests must be pre-certified.

6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

Exclusions include: infertility treatments, reproductive services other than prenatal care, labor and delivery, and care related to diseases illnesses or abnormalities related to the reproductive system.

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

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

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

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

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

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

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

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

Eyeglasses (limited to one (1) per year) and hearing aids (limited to one (1) every three (3) years) are covered services.

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

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

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

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

Benefits for home health nursing services must be approved by the Insurer's Utilization Review Program in lieu of hospitalization. Benefits for nursing services are limited to ten thousand dollars and zero cents (\$10,000.00) annually.

6.2.15. Nursing care services (Section 2110(a)(15))

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

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

Benefits for private duty nursing services are provided for an illness or injury that the Insurer's Utilization Review Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that the Insurer's Utilization Review Program determines to require the skills of an RN or LPN. Benefits for nursing services provided in an enrollee's home must be approved by the Insurer's Utilization Review Program in lieu of hospitalization. Benefits for nursing services are limited to ten thousand dollars and zero cents (\$10,000.00) annually. (This limit does not apply to nurse practitioner services.)

No nursing benefits are provided for:

- (1) Services of a nurse who ordinarily lives in the child's home or is a member of the child's family;
- (2) Services of an aide, orderly or sitter; or
- (3) Nursing services provided in a Personal Care Facility.

Benefits are provided for confinement in a skilled nursing facility for up to sixty (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)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Covered dental services are limited to two thousand dollars and zero cents (\$2,000.00) each calendar year (CY).

- (1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD), as indicated below:
 - a. Bitewing X-rays - as needed, but no more frequently than once every six (6) months;
 - b. Complete Mouth X-ray and Panoramic X-ray - as needed, but no more frequently than once every twenty-four (24) months;
 - c. Prophylaxis - one every six (6) months; must be separated by six (6) full months;
 - d. Fluoride Treatment - limited to one each six (6) month period;

- e. Space Maintainers - limited to permanent teeth through age 15 years; and
 - f. Sealants - covered up to age 14 years, every thirty-six (36) months.
- (2) Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below:
- a. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration;
 - b. Stainless steel crowns to posterior and anterior teeth;
 - c. Porcelain crowns to anterior teeth only;
 - d. Simple extraction;
 - e. Extraction of an impacted tooth;
 - f. Pulpotomy, pulpectomy, and root canal; and
 - g. Gingivectomy, gingivoplasty and gingival curettage.

Other Dental Services (The calendar year maximum does not apply to these services.)

- (1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an accidental injury.
- (2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. These services must be pre-certified.
- (3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is subject to a lifetime maximum benefit of five thousand dollars and zero cents (\$5,000.00) per Member. This lifetime maximum will apply regardless of whether the temporomandibular/craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

An exception to the annual dental benefit maximum of \$2,000 is if the Member:

- (1) Has a serious chronic illness or health condition and without the additional service, the Member's life would be in danger; or
- (2) Has a serious chronic illness or health condition and without the additional service, the Member's health would get much worse; or
- (3) Has a dental emergency defined as sudden onset of excessive pain, swelling or bleeding; or
- (4) Would need more expensive services if the exception is not granted; or delaying treatment would adversely impact the Member's dental health.

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) 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.
- (3) Certification of medical necessity by the Insurer's Utilization Review Program is required for admissions to a hospital or residential treatment center.
- (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 substance abuse do not include services for treatment of nervous and mental conditions.

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

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

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

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

Benefits are provided for physical therapy services specified in a plan of treatment

prescribed by the enrollee's practitioner and provided by a licensed physical therapist.

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

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

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

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

Benefits are provided for inpatient and home hospice services, subject to utilization management requirements. Benefits for hospice services are limited to an overall lifetime maximum of fifteen thousand dollars and zero cents (\$15,000.00).

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

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

Transplant Benefits:

(1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:

- (i) The enrollee or provider obtains prior approval from the Insurer's Utilization Management Program; and
- (ii) The condition is life-threatening; and
- (iii) Such transplant for that condition is the subject of an ongoing phase III clinical trial; and
- (iv) Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
- (v) The enrollee is a suitable candidate for the transplant under the medical protocols used by the Insurer's Utilization Management Program.

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

(3) Benefits are provided for transportation costs of recipient and two other individuals to

and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to ten thousand dollars and zero cents (\$10,000.00).

- (4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:
- (i) The following expenses are covered:
 - 1) A search for matching tissue, bone marrow or organ
 - 2) Donor's transportation
 - 3) Charges for removal, withdrawal and preservation, and
 - 4) Donor's hospitalization.
 - (ii) When only the recipient is enrolled in the Program, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient's contract.
 - (iii) When both the recipient and the donor are enrolled in the Program, the donor is entitled to benefits under the donor's contract.
 - (iv) When only the donor is a CHIP participant, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient.
 - (v) If any organ or tissue is sold rather than donated to the enrollee, no benefits are payable for the purchase price of such organ or tissue;

Manipulative therapy is a covered medical expense but benefits shall not exceed two thousand dollars and zero cents (\$2,000.00) annually.

Benefits are provided for medically necessary services and supplies required for the treatment of injury or disease of the eye which fall within the legal scope of practice of a licensed optometrist. Benefits are provided for annual routine eye examinations, eyeglasses, and the fitting of eyeglasses.

Benefits are provided for diabetes self-management training and education, including medical nutrition therapy, for the treatment of diabetes, subject to a limitation of two hundred fifty dollars and zero cents (\$250.00) per benefit period.

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

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

Professional ambulance services to the nearest hospital, which is equipped to handle the enrollee's condition in connection with covered hospital inpatient, care; or when related

to and within seventy-two (72) hours after accidental bodily injury or medical emergency whether or not inpatient care is required.

- 6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Limitations and Exclusions:

- a. For convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician for an enrollee who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall benefits be provided if the enrollee was admitted to a hospital for his or her own convenience or the convenience of his or her physician, or that the care or treatment provided did not relate to the condition for which the enrolled child was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the enrolled child was hospitalized and then only during such time as such services are medically necessary.
- b. For cosmetic purposes, except for correction of defects incurred by the enrollee while covered under the Program through traumatic injuries or disease requiring surgery.
- c. For sex therapy or marriage or family counseling.
- d. For custodial care, including sitters and companions.
- e. For equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, etc.).
- f. For procedures, which are Experimental/Investigative in nature.
- g. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
- h. For services and supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim to be medically necessary.
- i. For services which the Insurer's Utilization Review Program determines are not medically necessary for treatment of injury or illness.
- j. For services provided under any federal, state, or governmental plan or law including but not limited to Medicare except when so required by federal law.
- k. For nursing or personal care facility services i.e., extended care facility, nursing home, or personal care home, except as specifically described elsewhere.
- l. For treatment or care for obesity or weight control including diet treatment, gastric or intestinal bypass or stapling, or related procedures regardless of any claim of medical necessity or degree of obesity.

- m. For inpatient rehabilitative services consisting of the combined use of medical, social, educational or vocational services, or any such services designed to enable enrollees disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the Insurer's Utilization Review Program.
- n. For outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable enrollees disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the enrollee's physician and provided by a licensed therapist.
- o. For care rendered by a provider, (physician or other provider) who is related to the covered enrollee by blood or marriage or who regularly resides in the-enrolled child's household.
- p. For services rendered by a provider not practicing within the scope of his license at the time and place service is rendered.
- q. For treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease.
- r. For reversal of sterilization regardless of claim of medical necessity.
- s. For elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother.
- t. For charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim.
- u. For travel, whether or not recommended by a physician, except as provided for under Transplant Benefits.
- v. Because of diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
- w. For treatment of any injury arising out of or in the course of employment or any sickness entitling the enrollee to benefits under any Workers' Compensation or Employer Liability Law.
- x. For any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the enrollee is unable to recover from the responsible party, benefits shall be provided.
- y. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.

6.2-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services



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6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

6.2.2-DC Benchmark coverage; (Section 2103(c)(5), 42 CFR § 457.410, and 42 CFR § 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

6.2.2.3-DC HMO with largest insured commercial enrollment (Section

2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS Supplemental Dental Coverage- The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

6.3.2. The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Describe: Previously 8.6

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

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

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

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

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive

disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42 CFR § 457.1005(a))

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

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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

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

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

- Yes
 No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA: Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

- Yes
 No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

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. (Section 2102(a)(7)(A)) (42 CFR § 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)**

- 7.1.1. Quality standards
7.1.2. Performance measurement

7.1.2 (a) CHIPRA Quality Core Set

7.1.2 (b) Other

7.1.3. Information strategies

7.1.4. Quality improvement strategies

2102(a)(7)(B))

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

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42 CFR § 457.495(a))

The State establishes minimum requirements based on CHIPRA Quality Core Set and utilizes mandatory reporting requirements placed on the CCOs to monitor the number and rate of well-baby, well-child, well-adolescent visits and immunization rates by age group. The State establishes sanctions for noncompliance.

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

In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the CCOs shall meet the geographic access standards for all Members set forth in Table below.

Provider Type	Urban	Rural
PCPs	Two (2) within fifteen (15) miles	Two (2) within thirty (30) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Emergency Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within thirty (30) minutes or thirty (30) miles

Provider Type	Urban	Rural
Urgent Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	Not Applicable
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within thirty (30) minutes or thirty (30) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within sixty (60) minutes or sixty (60) miles
Dialysis Providers	One (1) within sixty (60) minutes or sixty (60) miles	One within ninety (90) minutes or ninety (90) miles

The Mississippi Division of Medicaid shall specify the urban and rural designation of counties within Mississippi. All travel times are maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider.

If the CCOs are unable to identify a sufficient number of Providers located within an area to meet the geographic access standards, or are unable to identify a sufficient number of Providers within a Provider type or specialty, the CCOs will submit documentation to the Mississippi Division of Medicaid verifying the lack of Providers. The Mississippi Division of Medicaid may approve exceptions to the geographic access standards in such cases.

The CCOs must pay for services covered under the contract on an out-of-network basis for the Member if the CCOs' Provider Network is unable to provide such services within the geographic access standards. The CCOs shall ensure that the cost to the Member is no greater than it would be if the services were furnished within the network. Services must be provided and paid for in an adequate and timely manner, as defined by the Mississippi Division of Medicaid, and for as long as the CCOs are unable to provide them.

The CCOs shall submit a Network Geographic Access Assessment (GeoAccess) Report on a quarterly basis to the Mississippi Division of Medicaid demonstrating compliance with these requirements.

The CCOs are also contractually required to provide coverage to Members on a 24-hours-per-day, 7-days-per-week basis. The CCOs must have written policies and procedures describing how Members and providers can contact the CCOs to receive individual instruction or referral for treatment of an emergency or urgent medical problem and to

receive instructions concerning how to access benefits when either in an area where network providers are not available and/or are not reasonably accessible. The policies and procedures must be made available in an accessible and understandable format upon request. Direct contact with qualified clinical staff must be made available to members through a toll-free nurse triage hotline telephone number.

Emergency services must be available at all times and provided upon arrival at the emergency room, or in the physician's office. If the physician or emergency room staff determines that the condition is not an emergency medical condition, the Member may be referred back to his/her physician for treatment after they are stabilized.

Coverage of emergency medical services are not subject to prior authorization requirements, but the CCOs may include a requirement that notice be given to the CCOs of use of non-participating providers for emergency services. Such notice requirements shall provide at least a 48-hour time frame after the emergency for notice to be given to the CCOs by the Member and/or the emergency provider. Utilization of and payments to non-participating providers may, at the CCOs option be limited to the treatment of emergency medical conditions, including medically necessary services rendered to the Member until such time as he/she can be safely transported to a network provider service location.

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

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

- 7.2.4** Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within fourteen (14) days after the receipt of a request for services. (Section 2102(a)(7)) (42 CFR § 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

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

The CCOs must make standard authorization decisions and provide notice within three (3) calendar days and/or two (2) business days per Minimum Standards for Utilization Review Agents issued by MSDH following receipt of the request for services. If the CCOs require additional medical information in order to make a decision, the CCOs will

notify the requesting provider of additional medical information needed and the CCOs must allow three (3) calendar days and/or two (2) business days for the requesting provider to submit the medical information. If the CCOs do not receive the additional medical information, the CCOs shall make a second attempt to notify the requestor of the additional medical information needed and the CCOs must allow one (1) business day or three (3) calendar days for the requestor to submit medical information to the CCOs.

Once all information is received from the provider, if the CCOs cannot make a decision, the three (3) calendar day and/or two (2) business day period may be extended up to fourteen (14) additional calendar days upon request of the Member or the provider to the CCOs, or if the CCOs justify to the Mississippi Division of Medicaid a need for additional information and how the extension is in the Member's best interest. The extension request to the Mississippi Division of Medicaid applies only after the CCOs have received all necessary medical information to render a decision and the CCOs require additional calendar days to make a decision. The CCOs must provide to the Mississippi Division of Medicaid the reason(s) justifying the additional calendar days needed to render a decision. The Mississippi Division of Medicaid will evaluate the CCOs' extension request and notify the CCOs of the decision within three (3) calendar days and/or two (2) business days of receiving the CCOs' request for extension.

The CCOs must expedite authorization for services when the provider indicates or the CCOs determine that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The CCOs must provide an Expedited Authorization Decision notice no later than twenty-four (24) hours after receipt of the expedited authorization request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, provider, or Contractor the CCOs. The CCOs must justify to the Mississippi Division of Medicaid a need for additional information and how the extension is in the Member's best interest. The extension request to the Mississippi Division of Medicaid applies only after the CCOs have received all necessary medical information to render a decision and the CCOs require additional calendar days to make a decision. The CCOs must provide to the Mississippi Division of Medicaid the reason(s) justifying the additional calendar days needed to render a decision. The Mississippi Division of Medicaid will evaluate the CCOs' extension request and notify the CCOs of the decision within three (3) calendar days and/or two (2) business days of receiving the CCOs' request for extension.

In accordance with 42 CFR § 457.1160, if a Member is denied prior authorization under the standard time frame for the internal review, the Division of Medicaid shall ensure the Member has access to an external review, as specified by 42 CFR § 457.1150(b), which must be completed within ninety (90) calendar days of the Member's request. If a Member is denied prior authorization under the expedited time frame for the internal review, the Division of Medicaid shall ensure the Member has access to an external review, as specified by 42 CFR § 457.1150(b), which must be completed within seventy-two (72) hours of the Member's request. The seventy-two (72) hour time frame may be extended by up to fourteen (14) calendar days, if the Member requests an extension.

Section 8. Cost-Sharing and Payment

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? (42 CFR § 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

- 8.1.1. Yes
- 8.1.2. No, skip to question 8.8.
- 8.1.1-PW Yes
- 8.1.2-PW No, skip to question 8.8.

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

8.2.1. Premiums: None

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

Requirement	≤150% FPL	151%-175% FPL	176% - 209% FPL
Per doctor visit	None	\$5.00	\$5.00
Per ER visit	None	\$15.00	\$15.00
Out-of-Pocket Maximum	N/A	\$800.00	\$950.00

8.2.4. Other:

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

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

8.2-DS Supplemental Dental (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent

of income calculation shall include all cost-sharing for health insurance and dental insurance (Section 2103(e)(1)(A)) (42 CFR § 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

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

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

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

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

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

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

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

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

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

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

Through the application process, the applicant self-declares his/her race and ethnicity. The Mississippi Division of Medicaid, the agency responsible for eligibility determination, notifies the CCO of an American Indian/Alaska Native enrollee through a specific code in the enrollment data transfer process. The Mississippi Division of Medicaid currently assigns out-stationed Medicaid specialists to take applications at the Indian Reservation.

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

8.7 Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR § 457.570 and 457.505(c))

Families are not dis-enrolled due to non-payment of co-payments. (Member booklet explains that a provider may refuse service if unpaid)

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

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

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

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

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

- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42 CFR § 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42 CFR § 457.622(b)(5))
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42 CFR § 457.475)
- 8.8.5. 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)) (42 CFR § 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

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)) (42 CFR § 457.710(b))

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

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

Performance Goal for Objective 1:

The capacity within the Mississippi Division of Medicaid was appropriately expanded or modified to conduct outreach, enrollment and eligibility determination activities as needed to enroll uninsured eligible children. These areas include data systems modification, eligibility determinations, enrollment, participation information, health service utilization, billing, health

status, provider information, personnel, (eligibility workers, administrative and support staff), staff training, publications and documents.

Performance Goals for Objective 2:

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

Performance Goals for Objective 3:

By January 1, 2015, at least 65,000 children between 100% and 209% FPL will be enrolled in CHIP or Medicaid.

Performance Goal for Objective 4:

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

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

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

Performance Goal for Objective 5:

At least 85% of children 2 years of age enrolled in CHIP will have received all appropriate immunizations.

At least 85% of CHIP enrollees who were 2 to 6 years of age will have received at least one (1) preventive or primary care visit during the year.

Performance Goals for Objective 6:

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

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42 CFR § 457.710(d))

The State has contracted with an analytics engine which provides expanded, age specific utilization data that will be used in monitoring the enrollment of the established performance goals for CHIP population. The CCOs will provide encounter data to the State's fiscal agent so that the analytics vendor can produce required reports and provide the data to the Mississippi Division of Medicaid for further analysis through the decision support system.

The fiscal agent and analytics engine will be able to measure and track the following Healthcare Effectiveness Data and Information Set (HEDIS) performance measures for the targeted CHIP population:

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

Objective 1:

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

Objective 2:

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

Objective 3:

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

Objective 4:

Access is measured by the CCOs using GeoAccess software applied to the CHIP enrollment file and network provider file.

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

Objective 5:

Satisfaction is measured by the CCOs through an annual Member satisfaction survey. Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well childcare
 - 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, list: Access to primary care
- 9.3.8. Performance measures for special targeted populations.
- 9.4. The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42 CFR § 457.720)
- 9.5. The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and

reports. (Section 2107(b)(2)) (42 CFR § 457.750)

The Medicaid agency uses the same staff to evaluate and assess CHIP quality of care-

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

In CHIP, the CCOs submit encounter data to the fiscal agent. The system generates standard reports and enables ad hoc reporting.

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

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

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

9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. Section 1132 (relating to periods within which claims must be filed)

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

The process of design and implementation of CHIP was open to allow input and participation from various interested and affected parties. Initial decisions were reached during the 1998 Legislative session in which Legislators received input from recipients, providers, advocates, the business community, medical care industry, and religious and political leaders. Phase I of CHIP was set forth in statute, together with a Commission to design Phase II. Phase I CHIP was publicized in the routine manner through the State of Mississippi's Administrative Procedures Act. The CHIP Commission was appointed, according to state statute, to develop proposals regarding benefits, funding, and eligibility of children. The CHIP Commission meetings were open to the public, as were the meetings of the three subcommittees established to develop recommendations with respect to structure, benefits and eligibility and outreach. Public hearings were held in four locations across the state, and an advance notice of these meetings was published in both the newspaper with statewide distribution as well as local papers. In addition,

the Mississippi Division of Medicaid authored news releases, editorials, and public service announcements on educational television and public radio. To date, information about and application for the State's CHIP is available on the Internet at the Mississippi Division of Medicaid's web page <http://www.medicaid.ms.gov>. The Mississippi Division of Medicaid has established statewide coalitions not only to assist with dissemination of MHB applications and materials but also to funnel families' experiences and concerns to the Mississippi Division of Medicaid. Finally, the Mississippi Division of Medicaid has maintained an extensive mailing list, and all materials and updates developed are distributed ongoing to all included therein.

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

- 9.9.1** Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR § 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42 CFR § 457.120(c))

The Mississippi Division of Medicaid consults with the tribe by notifying the Mississippi Band of Choctaw Indians designee, in writing with a description of the proposed change and direct impact, at least sixty (60) days prior to each submission by the State of any Medicaid SPA, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health programs, or Urban Indian Organizations (I/T/U) by email. The Deputy Health Director is the Mississippi Band of Choctaw Indians designee. Direct impact is defined as any Medicaid or CHIP program changes that are more restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to Indian Health Programs, Tribal Organizations, or Urban Indian Organization providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact I/T/U providers. If no response is received from the tribe within thirty (30) days, the Mississippi Division of Medicaid will proceed with the submission to the Centers for Medicare and Medicaid Services (CMS).

If the Mississippi Division of Medicaid is not able to consult with the tribe sixty (60) days prior to a submission, a copy of the proposed submission along with the reason for the urgency will be forwarded to the MBCI designee. A conference call with the designee and/or other tribal representatives will be requested to review the submission and its impact on the tribe. The Mississippi Division of Medicaid will then confirm the discussion via email and request a response from the designee to ensure agreement on the submission. This documentation will be provided as part of the submission information to CMS.

- 9.9.2** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR § 457.65(b) through (d). **9.9.2** Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

9.10. Provide a 1-year projected budget. Budget submitted with SPA #9, effective 01/01/2015.

	Federal Fiscal Year 2015 Oct - Sept Projected Costs
Enhanced FMAP rate	81.51%
Benefit Costs	
Insurance payments	
Managed care	215,775,000
per Member/per month rate @ # of eligibles	
Risk Assessment State Share Only (\$3)	2,520,000
Fee for Service	2,521,737
Total Benefit Costs	220,816,737
(Offsetting Member cost sharing payments)	
Net Benefit Costs	220,816,737
Administration Costs	
Personnel	
General administration	4,400,000
Contractors/Brokers (e.g., enrollment contractors)	-
Claims Processing	
Outreach/marketing costs	
Other	
Total Administration Costs	4,400,000
10% Administrative Cost Ceiling	24,535,193
Federal Share (multiplied by enhanced-FMAP rate)	\$183,574,162
State Share	\$41,642,574
TOTAL PROGRAM COSTS	225,216,737

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Note: The calendar year 2014 pmpm rate is \$264.83 and includes a \$3 risk assessment fee not eligible for federal match and we have approximately 70,000 members per month. The CY 2013 rate was \$245.01.

Note: Cost associated with the current SPA: \$0.00.

Section 10. Annual Reports and Evaluations

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)) (42 CFR § 457.750)**

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

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

10.3. The State assures that it will comply with all applicable Federal laws and regulations,

including but not limited to Federal grant requirements and Federal reporting requirements.

- 10.3-DC** Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! website. Please update Sections 6.2-DC and 9.10 when electing this option.

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

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

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

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

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

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

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

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

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

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

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

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

- 12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR § 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.**

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

12.2. Health Services Matters- Describe the review process for health services matters that comply with 42 CFR § 457.1120.

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

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

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	States		Associate Regional Administrator	Regional Office Address
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4 th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term `child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and pre-pregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
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.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by

State law and only if the service is

- a. Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
 - b. Performed under the general supervision or at the direction of a physician, or
 - c. Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
24. Premiums for private health care insurance coverage.
 25. Medical transportation.
 26. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
 27. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title—

1. **IN GENERAL-** Subject to paragraph (2), the term ‘targeted low-income child’ means a child—
 - a. who has been determined eligible by the State for child health assistance under the State plan;
 - b. (i) who is a low-income child, or
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
 - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include—
 - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
 - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.
5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term ‘targeted low-income pregnant woman’ means an individual—“(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; “(B) whose family income

exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and “(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. **CHILD-** The term `child' means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE-** The term `creditable health coverage' has the meaning given the term `creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms `group health plan', `group health insurance coverage', and `health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD -** The term `low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED-** The term `poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION-** The term `preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the terms `State child health plan' and `plan' mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD-** The term `uninsured child' means a child that does not have creditable health coverage.