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:Drew Snyder	Position/Title: Executive Director, MS Div. of Medicaid
Name: Janis Bond	Position/Title: Deputy Administrator, Office of Enrollment
Name: Jennifer Wentworth	Position/Title: Deputy Administrator, Office of Finance
Name: Tara Clark	Position/Title: Deputy Executive Director

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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.

Amendment #10 submitted: January 9, 2018 Implemented October 1, 2019
To include a Health Services Initiative offering vision services to low-income children throughout the state.

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 10: Effective Date 01/01/2018.

A notification letter with the draft CHIP SPA #10 was submitted to the Tribe on 12/15/2017, requesting an expedited review and submittal to CMS. The Tribe approved CHIP SPA #10 on 1/8/18.

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)

The Mississippi Division of Medicaid's CHIP CCOs will enroll non-profit providers (qualified provider) enrolled in both Mississippi Medicaid and CHIP to offer vision services to low-income children throughout the state. These services will not be reimbursed if the child has reached his/her benefit limits regarding a vision screening, eye exam and/or glasses/frames during the fiscal year. The program description and requirements of the qualified providers are as follows:

- The qualified provider will target Mississippi's low-income children by identifying Title I schools in which at least 51% of the student body qualifies to receive free or reduced price meals. In Mississippi, this includes 83% of schools statewide. The qualified provider will provide to the Division of Medicaid the list of schools where vision services will be provided. The Division of Medicaid's CHIP CCO will verify that each school on the list meets the 51% threshold for free or reduced price meals. The qualified provider will initially implement this HSI program in schools with the largest schools with the highest percentage of students eligible for free/reduced lunch (FRL) program first and then expand to additional schools in the state who meet the HSI criteria.
- The qualified provider will give all children in the targeted schools parental/guardian consent forms that require a parent/guardian's signature to opt-in or decline the services. The school will maintain a list of which children have opted-in and which children will not receive the services. Those children who do not have an opt-in consent form returned to the school will not receive the services.
- For children whose parents/guardians opt-in to receive the services, the qualified provider will perform one vision screening, one eye exam for those who fail the vision screening and, if needed, corrective lenses and frames, including replacements, as needed, on-site in a mobile eye clinic (for the eye exam) or within the school (for the vision screening and provision of glasses).
- The qualified provider will maintain an electronic medical record for each child that it serves, which will include the name of the child, services received, and other available identifying information (for example, date of birth, phone number and address) collected via the consent form. The qualified provider will submit CMS-1500 claims to the appropriate CHIP/Medicaid coordinated care organization (CCO), or the Division of Medicaid. The CHIP/Medicaid CCOs will pay the qualified provider based on negotiated, standard fees.
- The qualified provider will identify all children served aged 18 or younger who are not identified as enrolled in Medicaid fee-for-service, a Medicaid/CHIP CCO or as having private vision insurance. The qualified provider will submit these uninsured children's information including at a minimum, the child's name, date of birth, services provided and date of service to the Mississippi Division of Medicaid's CHIP CCO which will remit payment to the qualified provider for these services through CHIP HSI funding.
- The HSI will target only children/youth under the age of 19.
- The Division of Medicaid assures this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Mississippi estimates that approximately 2,500-3,000 children will receive services (an exam, and glasses as needed) through CHIP HSI funding on an annual basis. An updated budget is included in Section 9.10.

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 (IHCIA). 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 (MBCI) designees, in writing, with a description of the proposed changes and direct impact, at least thirty (30) days prior to each submission by the State of any CHIP SPA that is likely to have a direct effect on Indians, Indian Health programs, or Urban Indian Organizations (I/T/U) by email. MCBI designees are the Choctaw Health Center's Deputy Director and the Director of Financial Services.. 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 CHIP proposals 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 thirty (30) 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. The Tribe may waive this notification time-frame requirement in writing via e-mail. If requested, a conference call with the MCBI 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 Choctaw Health Center's Deputy Health Director and Director of Financial Services were notified by e-mail on December 15, 2017, of the proposed CHIP #10 submission. An expedited submission was requested. The Tribe approved CHIP SPA #10 on 1/8/18.

9.10. Provide a 1-year projected budget. Budget submitted with MS SPA 18-0010-CHIP, effective 10/01/2019.

	Federal Fiscal Year 2020 Oct - Sept Projected Costs
Enhanced FMAP rate	**95.39%**
Benefit Costs	
Insurance payments	
Managed care	156,220,634
per member/per month rate @ # of eligibles	277.59 PM/PM – 49,600 eligibles
Risk Assessment State Share Only ($3)	
Fee for Service	2,700,000
Total Benefit Costs	**158,920,634**
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	158,920,634
Administration Costs	
Personnel	3,242,025
General administration	300,000
Contractors/Brokers (e.g., enrollment contractors)	-
Claims Processing	
Outreach/marketing costs	
Other	
Health Services Initiative	288,000
Total Administration Costs	3,830,025
10% Administrative Cost Ceiling	17,657,848
Federal Share (multiplied by enhanced-FMAP rate)	155,247,854
State Share	7,502,805
TOTAL PROGRAM COSTS	**162,750,659**

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