

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))

(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, Division of Medicaid
Name: Janis Bond	Position/Title: Deputy Administrator, Enrollment
Name: Margaret King	Position/Title: Chief Financial Officer

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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. (42CFR 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

Amendment #2 submitted: September 22, 1999

Amendment #3 submitted: July 6, 2000

Amendment #4 submitted: July 3, 2001

Implemented January 1, 2000

Implemented January 1, 2000

Implemented October 1, 2000

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 CHIP program in MS for the oversight of the separate health plan to the MS Division of Medicaid; inclusion of covered dental benefits required by CHIPRA; clarification of enrollee coverage provided in an emergency department.

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 Effective Date 07/01/2013

CHIP SPA Number 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 is in accordance with Mississippi’s tribal consultation process that includes notifying the tribal designees in writing at least 60 days prior to each formal submission of Medicaid or CHIP State Plan amendments 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 the CHIP program to the Division of Medicaid in a face to face meeting that occurred on October 15, 2012 between tribal staff and Medicaid program staff held to discuss other SPA-related proposals. There was no formal response by tribal officials to the submission of SPA #8 changes submitted for their review on January 4, 2013.

The Tribe was notified October 29, 2013 the effective date was changed to July 1, 2013 instead of January 1, 2013.

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

According to the Behavioral Risk Factor Surveillance System, 16% of Mississippi's population is currently under 100% of the Federal Poverty Level, or approximately 340,479.

Twenty-one percent of the families in Mississippi have children under age 18.

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

Medicaid Eligibles

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

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

CHIP

Mississippi originally implemented its SCHIP in July 1998 with a Medicaid expansion program for children 15-18 years at 100% FPL. This phase of the program ended as of October 01, 2002. To date, the State's CHIP targets all children in the state below age 19 who are below 200% FPL, not eligible for Medicaid coverage, and have no other health coverage. According to Census and MMIRS data, it was estimated there are approximately 65,000- 85,000 uninsured children in the state below age 19 who are below 200% FPL and do not qualify for Medicaid. The goal is to assess these children for CHIP eligibility under a health coverage package. As of August 2005, over 66,000 children are enrolled in CHIP.

2.2. 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)

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 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 State Plan Amendment, 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 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 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 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 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 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. Face-to-face meetings have been held on July 10, 2012, October 15, 2012, March 8, 2013, June 18, 2013. The next meeting is scheduled to take place in October 2013.

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) (42CFR 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

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

- (a) Defining the scope and coverage provided by the insurance plans;

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

The Department of Finance and Administration (DFA) is authorized by this same law to provide staff assistance to the Board and to employ a State Insurance Administrator, who is responsible for the day-to-day management and administration of the insurance plans. The State Insurance Administrator oversees the Office of Insurance which also has responsibility for administering the State Agencies' Workers' Compensation Trust and the State and School Employees' Life and Health Insurance Plan.

Effective January 1, 2013, the MS Children's Health Insurance Program and the current contract for insurance services is transferred from the Health Insurance Management Board to the Division of Medicaid. The division is then responsible for the administration and management of the MS CHIP program which includes all authority previously granted to the Health Insurance Management Board.

Management of Coverage

The Health Insurance Management Board selected Blue Cross/Blue Shield of MS (BCBSMS) as the fully insured provider for the Children's Health Insurance Program in 2000, and again in 2004 through a competitive bid process for health insurance coverage for children eligible for CHIP. Similarly, United HealthCare of Mississippi (UHC-MS) was selected to provide fully insured health insurance coverage in 2010. The Board defines the minimum level of benefits to be provided by the contractor (see Section 6.2). Currently, UHC-MS provides enrollment, financial accounting services, and insurance coverage for the eligible population on a statewide basis. Such services include, but are not limited to, the following:

- (a) Collecting enrollment data on eligible participants;
- (b) Responding to inquiries from potentially eligible families;
- (c) Providing a description of coverage and ID cards to enrolled participants;
- (d) Adjudicating claims;
- (e) Implementing an internal appeals process;
- (f) Processing payment to providers;
- (g) Responding to inquiries and complaints from members and providers;
- (h) Implementing appropriate utilization management;
- (i) Ensuring adequate access to providers;
- (j) Producing required and requested reports;
- (k) Submitting encounter data to the State's Data Management Vendor;
- (l) Maintaining proper financial controls and reporting.; and
- (m) Conducting required data matches.

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

Employer-Sponsored Insurance Subsidy Feature

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

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

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

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

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

- (a) The actuary will compare the employer’s Summary Plan Description to the benchmark plan’s benefits on a benefit by benefit basis (see attached checklist).
- (b) If the employer’s plan of benefits match the benchmark plan’s benefits on a benefit by benefit basis (without regard to cost sharing), the employer’s plan will be considered to have passed this criterion and will be evaluated for cost.
- (c) If the employer’s plan of benefits does not match on a benefit by benefit basis, the plan may be rejected by the actuary as not equivalent to the benchmark plan or may undergo a full actuarial analysis by the actuary to compare the overall

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

- (d) The State will submit copies of the benefit comparisons and actuarial analyses to CMS upon request. Children who qualify for payment of premiums under an employer-sponsored plan will receive "secondary" or "wrap-around" supplemental coverage under Mississippi's CHIP plan to cover deductibles, co-insurance, co-payments, and pre-existing conditions. Providers will be asked to file claims for these amounts after the primary carrier has allowed benefits and issued an explanation of benefits. In order to ensure that families are not required to pay more than the specified co-payments, if any, under CHIP, the State's communications to providers upon the implementation of CHIP will include the following information on cost sharing:
- (a) There are no cost sharing requirements for children enrolled in CHIP except for the minimal co-payments for families over 150% of FPL;
 - (b) Any charges for deductibles, co-insurance, or co-payments under employer-sponsored plans are to be filed with the State's CHIP insurer;
 - (c) The federal law governing CHIP prohibits cost sharing with respect to benefits for well child care, including immunizations, and families may not be required to pay for these services at the point of service; and
 - (d) There is no cost sharing for American Indian/Alaska Native children.

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

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

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

Section 4. Eligibility Standards and Methodology

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. (42CFR 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.

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 – 185% FPL to 200% FPL.
 Age 1 to age 6 – 133% FPL to 200% FPL
 Age 6 to age 19 – 100% FPL to 200% 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 12 months:

12 months from the effective date of coverage for CHIP or until the child reaches age 19 years 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 eligible children under age 19 are granted 12 continuous months of eligibility unless the child reaches age 19, dies, moves out of state, is admitted to a public institution or voluntarily requests that coverage be discontinued prior to the end of the 12 month period that begins with the initial effective date of coverage and is extended at each annual review provided the child is determined eligible for continuing coverage.

- 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)) (42CFR, 457.350)

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

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

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

4.3.1 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)) (42CFR, 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. MS 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)) (42CFR, 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)) (42CFR, 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)) (42CFR, 457.805) (42CFR 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 separate health plan insurer discovers a claim submitted listing any other insurance coverage for an eligible CHIP child, the insurer provides this information to the State Office of the Division of Medicaid for further investigation. Pending the findings, CHIP eligibility may or may not be terminated. MS previously eliminated a 6-month waiting period in October 2000. At the time the waiting period was eliminated, the state agreed to monitor on a monthly basis the number of children approved with prior creditable health insurance in the previous 6 months as declared on the application for benefits. When the number of children enrolled with prior coverage is 15% of the total CHIP children approved, the implementation of a new waiting period would be considered. However, the percentage of children approved with prior coverage has remained below 4%.

- 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) (42CFR 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 FQHC's, newly-funded school health nurses, and several Indian Health Service Clinics. In addition, the Children's Medical Program provides specialty care to uninsured and Medicaid enrolled children with special health care needs. The Department of Mental Health (DMH) provides mental health services to children through their Community Mental Health Clinics on a sliding scale fee arrangement based upon the patient's declared income. These entities currently identify and help enroll children who are eligible for Medicaid coverage and will be used to identify and enroll non-covered children who are eligible to participate in the CHIP as well as the Medicaid program. The Department of Education (DOE) has signed a

memorandum of understanding with the Division of Medicaid (DOM) to assist with the identification and enrollment for CHIP. Program information presentations are provided on an on-going basis to schools and Head Starts in the state, inviting families to apply for health benefits (Medicaid or CHIP). Applications, pamphlets, flyers, and posters are being widely distributed together with informational brochures in Spanish and Vietnamese, as well as English.

Mississippi State Health Department

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

Mississippi Department of Human Services (DHS)

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

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

Department of Education (DOE)

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

Mississippi Division of Medicaid (DOM)

This agency provides a statewide system of medical assistance, health care, remedial and institutional services under Titles XXI, XIX and XVIII of the Social Security Act. In partnership with the Department of Human Services, Department of Health, Department of Education, and the Department of Mental Health, the Division identifies and enrolls Medicaid eligible children. This partnership has been maintained and strengthened to identify and enroll CHIP eligible children. The State Department of Health and the Department of Mental Health serve as providers of services to Medicaid/CHIP eligible children and to uninsured children. The Division of Medicaid works with these agencies and a statewide coalition of other partners to identify, enroll and retain eligible children for MS Health Benefits Program (Medicaid and CHIP). In addition, the Division of Medicaid has expanded its school-based providers of EPSDT screening and treatment services. Through this avenue, the Medicaid agency will be able to utilize the schools to identify Medicaid eligible and CHIP eligible children. With out-stationed workers in federally qualified health centers (FQHCs), disproportionate share hospitals (DSH) hospitals and Health Department Clinics, the Medicaid agency will utilize these service providers to identify Medicaid and CHIP eligible children. The Medicaid agency will increase its reliance on

primary care providers (PCP) through its fee-for-services providers to disseminate information about eligibility for both Medicaid and CHIP for children through its Medical Advisory Committee. The Medicaid agency established the State CHIP Steering Committee that is composed of representation from the Department of Finance and Administration (DFA), Department of Health, Department of Human Services (DHS), and the Department of Mental Health in order to be comprehensive in its approach in the provision of quality health services to all children. This committee meets quarterly, reviews program operations and gives recommendations.

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:

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

Because of lack of any private insurance initiatives for children and families unable to afford any other kind of health care coverage, the 1998 Mississippi Legislature did establish the Mississippi Children's Health Insurance Program Commission, which explored the feasibility of a public-private partnership for children's health care for targeted low-income children who do not qualify for Medicaid. DOM has received a HRSA State Planning Grant to identify potential health policy options for the under and uninsured through the establishment of public-private partnerships. The final report from that grant will be available by August 31, 2006.

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))(42CFR 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. DOM does have on-going communication with private health insurance groups, present at their professional meetings, provides program information and updates and has an exchange of referrals.

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.

5.3 Strategies

Outreach

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

- (a) Reduced barriers to participation by using the same “short form” currently used to determine eligibility for Medicaid and CHIP; by streamlining income verification processes; dispensing with resource and asset tests for children, and by wide dissemination of application and information.;
- (b) Engaged in provider education efforts because providers are a vital link to this population;
- (c) Initiated cooperative efforts with the State Department of Health, the Department of Human Services, Department of Mental Health, Department of Education, the Department of Rehabilitation Services and Head Start regarding public awareness of these two programs;
- (d) Developed statewide coalitions to assist with the dissemination of materials and conducting a variety of outreach strategies such as health fairs and forums, development of informational fliers, posters, and other promotional items;
- (e) Engaged the print media as a means to educate providers;
- (f) Coordinated a number of community based initiatives to educate families with potentially eligible children;

- (g) Partnered with entities and programs through local and state inter-agency councils, school-based health programs, including Head start, and other community organizations whose missions include services to families and children;
- (h) Out stationed Medicaid specialists at FQHCs, Disproportionate Share Hospitals, County Health Departments, Indian reservations, and through school-based EPSDT providers; and
- (i) Coordinated with the Department of Education, mechanisms to identify children in the targeted population for outreach activities and assessment for eligibility as well as provide another avenue for dissemination of information about CHIP.

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

Special Populations

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

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

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

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

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

Section 6. Coverage Requirements for Children’s Health Insurance

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)); (42CFR 457.410(a))

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

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1) (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)) (42CFR 457.490)

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

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

- (1) Hospital room and board (including dietary and general nursing services)
- (2) Use of operating or treatment rooms.
- (3) Anesthetics and their administration.
- (4) Intravenous injections and solutions.
- (5) Physical therapy.
- (6) Radiation therapy.
- (7) Oxygen and its administration.
- (8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms.
- (9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs.
- (10) Dressings and Supplies, sterile trays, casts, and orthopedic splints.

- (11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.
- (12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations.
- (13) Intensive, Coronary, and Burn Care Unit services.
- (14) Occupational therapy.
- (15) Speech therapy.

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

6.2.3. ☒ Physician services (Section 2110(a)(3))

Includes the following:

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

- (12) Well child assessments, including vision screening, laboratory tests and hearing screening, according to recommendations of the U.S. Preventive Service Task Force.
Vision and hearing screening are to be included as part of the periodic well child assessments.
- (13) Routine immunizations (according to ACIP guidelines)-Vaccine is purchased and distributed through the State Department of Health. The health plan will reimburse providers for the administration of the vaccine.

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

Certain surgeries must be pre-certified as medically necessary.

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

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

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

Covered as medical services (refer to 6.2.3.).

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

The following drugs and medical supplies are covered:

- (1) Legend drugs (federal law requires these drugs be dispensed by prescription only)
- (2) Compounded medication of which at least one ingredient is a legend drug
- (3) Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape)
- (4) Disposable insulin needles/syringes
- (5) Growth hormones
- (6) Insulin
- (7) Lancets
- (8) Legend contraceptives
- (9) Retin-A
- (10) Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets)

- (11) Vitamin and mineral supplements, when prescribed as replacement therapy

The following are excluded:

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

- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
Certain diagnostic tests must be pre-certified.
- 6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
Infertility services are excluded.
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but

including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

- (1) Benefits for Covered Medical Expenses are paid for medically necessary inpatient psychiatric treatment of an enrollee.
- (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 per year) and hearing aids (limited to one every three years) are covered services.

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

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

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

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

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

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

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

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

Benefits for private duty nursing services are provided for an illness or injury that the Insurer's Utilization Review Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that

the Insurer's Utilization Review Program determines to require the skills of an RN or LPN. Benefits for nursing services provided in an enrollee's home must be approved by the Insurer's Utilization Review Program in lieu of hospitalization. Benefits for nursing services are limited to \$10,000 annually. (This limit does not apply to nurse practitioner services.)

No nursing benefits are provided for:

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

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

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

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

- 6.2.17.** Dental services (Section 2110(a)(17)) 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 \$1500 each calendar year

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

- (2) Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below, and are limited to \$1500 each calendar year.
- a. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration;
 - b. Stainless steel crowns to posterior and anterior teeth;
 - c. Porcelain crowns to anterior teeth only;
 - d. Simple extraction;
 - e. Extraction of an impacted tooth;
 - f. Pulpotomy, pulpectomy, and root canal; and
 - g. Gingivectomy, gingivoplasty and gingival curettage.

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

(1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an accidental injury.

(2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. These services must be pre-certified.

(3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is subject to a lifetime maximum benefit of \$5,000 per member. This lifetime maximum will apply regardless of whether the temporomandibular / craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

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

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

- (1) Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance abuse treatment.
- (2) 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 \$15,000.

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

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

Transplant Benefits:

- (1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:
 - (i) The enrollee or provider obtains prior approval from the Insurer's Utilization Management Program; and
 - (ii) The condition is life-threatening; and
 - (iii) Such transplant for that condition is the subject of an ongoing phase III clinical trial; and
 - (iv) Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and

- (v) The enrollee is a suitable candidate for the transplant under the medical protocols used by the Insurer's Utilization Management Program.
- (2) In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.
- (3) Benefits are provided for transportation costs of recipient and two other individuals to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to \$10,000.
- (4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:
 - (i) The following expenses are covered:
 - A search for matching tissue, bone marrow or organ
 - Donor's transportation
 - Charges for removal, withdrawal and preservation
 - Donor's hospitalization
 - (ii) When only the recipient is a enrolled in the Program, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient's contract.
 - (iii) When both the recipient and the donor are enrolled in the Program, the donor is entitled to benefits under the donor's contract.
 - (iv) When only the donor is a Plan participant, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient.
 - (v) If any organ or tissue is sold rather than donated to the enrollee, no benefits are payable for the purchase price of such organ or tissue;

Manipulative therapy is a covered medical expense but benefits shall not exceed \$2,000 annually.

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

for annual routine eye examinations, eyeglasses, and the fitting of eyeglasses.

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

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

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

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

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

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

Limitations and Exclusions:

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

- e. For equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, etc.).
- f. For procedures, which are Experimental/Investigative in nature.
- g. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
- h. For services and supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim to be medically necessary.
- i. For services which the Insurer's Utilization Review Program determines are not medically necessary for treatment of injury or illness.
- j. For services provided under any federal, state, or governmental plan or law including but not limited to Medicare except when so required by federal law.
- k. For nursing or personal care facility services i.e., extended care facility, nursing home, or personal care home, except as specifically described elsewhere.
- l. For treatment or care for obesity or weight control including diet treatment, gastric or intestinal bypass or stapling, or related procedures regardless of any claim of medical necessity or degree of obesity.
- m. For inpatient rehabilitative services consisting of the combined use of medical, social, educational or vocational services, or any such services designed to enable enrollees disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the Insurer's Utilization Review Program.
- n. For outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable enrollees disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the enrollee's physician and provided by a licensed therapist.
- o. For care rendered by a provider, (physician or other provider) who is related to the covered enrollee by blood or marriage or who regularly resides in the-enrolled child's household.
- p. For services rendered by a provider not practicing within the scope of his license at the time and place service is rendered.
- q. For treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease.
- r. For reversal of sterilization regardless of claim of medical necessity.
- s. For elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother.
- t. For charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim.

- u. For travel, whether or not recommended by a physician, except as provided for under Transplant Benefits.
- v. Because of diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
- w. For treatment of any injury arising out of or in the course of employment or any sickness entitling the enrollee to benefits under any Workers' Compensation or Employer Liability Law.
- x. For any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the enrollee is unable to recover from the responsible party, benefits shall be provided.
- y. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.

6.2-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:

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Mississippi CHIP Plan Covered Services \$1,500 Annual Maximum - No Deductible

*PROCEDURES NOT LISTED ARE NOT A BENEFIT OF THIS PLAN - IF YOU HAVE A QUESTION REGARDING PLAN BENEFITS,
PLEASE CONTACT PROVIDER SERVICES FOR ASSISTANCE.*

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D0120	PERIODIC ORAL EVALUATION	YES	0	19	1 EVERY 6 MONTHS	NO
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	YES	0	19	N/A	NO
D0145	ORAL EVALUATION FOR PATIENT UNDER 3	YES	0	3	1 EVERY 6 MONTHS	NO
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	YES	0	19	1 EVERY 6 MONTHS	NO
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	YES	0	19	1 EVERY 24 MONTHS	NO
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	YES	0	19	N/A	NO
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	YES	0	19	N/A	NO
D0240	INTRAORAL-OCCLUSAL FILM	YES	0	19	N/A	NO
D0270	BITEWING-SINGLE FILM	YES	0	19	1 EVERY 6 MONTHS	NO
D0272	BITEWINGS-TWO FILMS	YES	0	19	1 EVERY 6 MONTHS	NO
D0273	BITEWINGS - THREE FILMS	YES	0	19	1 EVERY 6 MONTHS	NO
D0274	BITEWINGS-FOUR FILMS	YES	0	19	1 EVERY 6 MONTHS	NO
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	³ SEE TMJ DISORDER BENEFIT	0	19	³ SEE TMJ DISORDER BENEFIT	YES
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY REPORT	³ SEE TMJ DISORDER BENEFIT	0	19	³ SEE TMJ DISORDER BENEFIT	YES
D0330	PANORAMIC FILM	YES	0	19	1 EVERY 24 MONTHS	NO
D1110	PROPHYLAXIS-ADULT - AGE 14+	YES	14	19	1 EVERY 6 MONTHS	NO
D1120	PROPHYLAXIS-CHILD - AGE 0 -13	YES	0	13	1 EVERY 6 MONTHS	NO
D1203	TOPICAL APPLICATION OF FLUORIDE - CHILD	YES	0	13	1 EVERY 6 MONTHS	NO

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D1204	TOPICAL APPLICATION OF FLUORIDE - ADULT	YES	14	19	1 EVERY 6 MONTHS	NO
D1206	TOPICAL FLUORIDE VARNISH; MODERATE TO HIGH RISK PATIENTS	YES	0	6	1 EVERY 6 MONTHS	NO
D1351	SEALANT - PER TOOTH	YES	0	14	1 EVERY 36 MONTHS MOLARS ONLY	NO
D1510	SPACE MAINTAINER - FIXED - UNILATERAL	YES	0	15	PERMANENT TEETH ONLY	NO
D1515	SPACE MAINTAINER - FIXED - BIILATERAL	YES	0	15	PERMANENT TEETH ONLY	NO
D1520	SPACE MAINTAINER - REMOVABLE UNILATERAL	YES	0	15	PERMANENT TEETH ONLY	NO
CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D1525	SPACE MAINTAINER - REMOVABLE BILATERAL	YES	0	15	PERMANENT TEETH ONLY	NO
D1550	RECEMENTATION OF SPACE MAINTAINER	YES	0	15	N/A	NO
D1555	REMOVAL OF FIXED SPACE MAINTAINER	YES	0	15	N/A	NO
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2330	RESIN BASED COMPOSITE-ONE SURFACE, ANTERIOR	YES	0	19	N/A	NO
D2331	RESIN BASED COMPOSITE-TWO SURFACES, ANTERIOR	YES	0	19	N/A	NO
D2332	RESIN BASED COMPOSITE-THREE SURFACES, ANTERIOR	YES	0	19	N/A	NO
D2335	RESIN BASED COMPOSITE-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE	YES	0	19	N/A	NO
D2391	RESIN BASED COMPOSITE-ONE SURFACE, POSTERIOR	YES	0	19	N/A	NO
D2392	RESIN BASED COMPOSITE-TWO SURFACES, POSTERIOR	YES	0	19	N/A	NO
D2393	RESIN BASED COMPOSITE-THREE SURFACES, POSTERIOR	YES	0	19	N/A	NO

D2394	RESIN BASED COMPOSITE-FOUR OR MORE SURFACES POSTERIOR	YES	0	19	N/A	NO
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	YES	0	19	1 EVERY 5 YRS ANTERIOR TEETH ONLY	YES
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	YES	0	19	1 EVERY 5 YRS ANTERIOR TEETH ONLY	YES
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	YES	0	19	N/A	NO
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	YES	0	19	N/A	YES
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	YES	0	19	ANTERIOR TEETH ONLY	NO
D2940	SEDATIVE FILLING	YES	0	19	N/A	NO
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	YES	0	19	N/A	NO
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	YES	0	19	N/A	NO
D3230	PULPAL THERAPY (RESORBABLE FILLING) ANTERIOR PRIMARY TOOTH	YES	0	6	N/A	NO
D3240	PULPAL THERAPY (RESORBABLE FILLING) POSTERIOR PRIMARY TOOTH	YES	0	10	N/A	NO
D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D3320	BICUSPID (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
D3330	MOLAR (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH	YES	0	19	1 EVERY 36 MONTHS	YES
D4211	GINGIVECTOMY OR GINGIVOPLASTY- 1 TO 3 TEETH PER QUADRANT	YES	0	19	1 EVERY 36 MONTHS	YES

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D4341	PERIODONTAL SCALING AND ROOT PLANING- FOUR OR MORE TEETH, PER QUADRANT	YES	10	19	2 QUADS PER VISIT 4 QUADS PER YEAR	YES
D4342	PERIODONTAL SCALING AND ROOT PLANING- ONE TO THREE TEETH, PER QUADRANT	YES	10	19	2 QUADS PER VISIT 4 QUADS PER YEAR	YES
D5110	COMPLETE UPPER	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5120	COMPLETE LOWER	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5211	UPPER PARTIAL-RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5212	LOWER PARTIAL-RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5213	UPPER PARTIAL-CAST METAL FRAMEWORK WITH RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D5214	LOWER PARTIAL-CAST METAL FRAMEWORK WITH RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7140	EXTRACTION, ERUPTED OR EXPOSED TOOTH (ELEVATION AND/OR FORCEPS REMOVAL)	YES	0	19	1 PER LIFETIME PER TOOTH	NO
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION	YES	0	19	1 PER LIFETIME PER TOOTH	NO
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	YES	0	19	1 PER LIFETIME PER TOOTH	YES
CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D7270	TOOTH REPLANTATION AND/OR STABILIZATION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES

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D7780	FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7810	OPEN REDUCTION OF DISLOCATION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7820	CLOSED REDUCTION OF DISLOCATION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7830	MANIPULATION UNDER ANESTHESIA	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7840	CONDYLECTOMY	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7850	SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7860	ARTHROTOMY	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D7870	ARTHROCENTESIS	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D9220	DEEP SEDATION- GENERAL ANESTHESIA-FIRST 30 MINUTES	YES	0	19	² WHEN CLINICALLY NECESSARY	YES
D9221	DEEP SEDATION- GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES	YES	0	19	² WHEN CLINICALLY NECESSARY	YES
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE	YES	0	7	ALLOWABLE WITH RESTORATIVE PROCEDURES ONLY 1 PER VISIT/DAY	NO
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN	YES	0	19	N/A	NO
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN	YES	0	19	N/A	NO

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D9951	OCCLUSAL ADJUSTMENT - LIMITED	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	¹ SEE ACCIDENTAL INJURY BENEFIT	0	19	¹ SEE ACCIDENTAL INJURY BENEFIT	YES
PROCEDURES NOT LISTED ARE NOT A BENEFIT OF THIS PLAN - IF YOU HAVE A QUESTION REGARDING PLAN BENEFITS, PLEASE CONTACT PROVIDER SERVICES FOR ASSISTANCE.						

¹ ACCIDENTAL INJURY BENEFIT - THE CALENDAR YEAR MAXIMUM DOES NOT APPLY TO THESE SERVICES
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 Member is covered under the plan. Injury to teeth as a result of chewing or biting is not considered accidental injury. **FOR ACCIDENTAL INJURY BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURE CODES FOR PRE-AUTHORIZATION APPROVAL.**

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. **FOR ORTHODONTIC BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURE CODES FOR PRE-AUTHORIZATION APPROVAL.**

² ANESTHESIA BENEFITS
Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the Member requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office.

³ TMJ COVERAGE BENEFIT
Benefits are provided for diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a Practitioner or dentist, subject to a lifetime maximum benefit of \$5,000 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. **FOR TMJ BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURES FOR PRE-AUTHORIZATION APPROVAL.**

- 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: (42CFR 457.480)

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

6.3.2. The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (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 (42CFR 457.1005(a)):

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

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

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

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

6.4.2.1. Purchase of family coverage is cost-effective. 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)) (42CFR 457.1010(b))

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

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)) (42CFR 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

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

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

7.1.4.

Quality improvement strategies

2102(a)(7)(B))

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

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

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

The Health Plan is required to make available to members the opportunity to access network providers within the travel distances indicated below, or must arrange/allow for care to be rendered by non-participating providers who are within a closer proximity. For purposes of the access standards, the term urban/suburban area is defined as a zip code with a population density of 1,000 or more persons per square mile and a rural area is defined as a zip code with a population density of less than 1,000 or more persons per square mile.

- One primary care physician whose office is within 15 miles in urban/suburban areas or 25 miles in rural areas (unless none are located within such a distance) from the member's place of residence.
- Appropriate specialty care within 20 miles in urban/suburban or 30 miles in rural areas (unless none are located within such a distance) from the member's place of residence.
- Hospital inpatient (i.e., acute med/surg) and emergency room services shall be within 25 miles in urban/suburban areas, or 45 miles in rural areas (unless none are located within such a distance) from the member's place of residence.
- One pharmacy located within 15 miles in urban/suburban areas or 25 miles in rural areas (unless none are located within such a distance) from the member's place of residence.
- One dentist and one optometrist or ophthalmologist whose office is within 20 miles in urban/suburban areas or 30 miles in rural areas (unless none are located within such a distance) from the member's place of residence.

The Health Plan is required to produce (using GeoAccess or similar software) and submit access reports following the end of each calendar quarter and contract year. The match is to be conducted separately for each provider type for urban/suburban zip code areas and for rural zip code areas. The elements used to measure member access are as follows:

- The five digit zip code census of covered members as of the end of the measurement period; and
- The five-digit zip code census of the provider network (using the address of their practice locations) under contract as of the end of the measurement period.

The Health Plan's compliance is evaluated at the end of each contract year. The calendar quarter-end reports are used to monitor the Health Plan's performance. Liquidated damages are assessed if the access for the contract year-end under review for any provider type was not in compliance with the performance standard.

The Health Plan is also contractually required to provide coverage to members on a 24-hours-per-day, seven-days-per-week basis. The Health Plan must have written policies and procedures describing how members and providers can contact the Health Plan 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 Health Plan may include a requirement that notice be given to the Health Plan 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 Health Plan by the member and/or the emergency provider. Utilization of and payments to non-participating providers may, at the Health Plan's 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)) (42CFR 457.495(c))

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

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

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

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

Section 8. Cost-Sharing and Payment

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

- 8.1.** Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) 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)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: None

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

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

8.2.4. Other:

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)) (42CFR 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 health plan maintains the cost sharing accounting for the participant. When a participant has met his/her out of pocket maximum, the health plan sends a letter to the participant indicating that no further co-payments should be made for the remainder of the calendar year. The participant is instructed to present this letter when future health services are sought, or request the provider to contact the health plan regarding this issue.

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

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

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

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

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

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

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

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

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

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

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

Families are not dis-enrolled due to non-payment of 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. (42CFR 457.570(b))
- In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

- 8.8.1.** No Federal funds will be used toward State matching requirements. (Section 2105(c)(4) (42CFR 457.220))
- 8.8.2.** No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5))
- 8.8.3.** No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4.** Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section

- 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.5. ☒ 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)) (42CFR 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)) (42CFR 457.710(b))
1. The infrastructure of the Mississippi Medicaid agency will be able to accommodate all critical facets of outreach and eligibility determination for the Title XXI program.
 2. Previously uninsured children who will potentially be eligible for Mississippi's Title XXI program will be identified through ongoing outreach activities involving other state agencies, social/healthcare providers, schools, Head Start, community/faith-based organizations, and advocates.
 3. Low income children who were previously without health insurance coverage will have health insurance coverage through Mississippi's Title XXI program.
 4. Children enrolled in CHIP will have adequate access to primary care, inpatient care, and pharmacy services.
 5. Children enrolled in CHIP will receive appropriate preventive and primary care services.
 6. Families of CHIP enrollees will be surveyed annually regarding their satisfaction with the services provided under the Program
- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Performance Goal for Objective 1:

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

Performance Goals for Objective 2:

- (1) The Medicaid agency has re-evaluated its existing outreach activities and developed materials for wide-spread dissemination throughout the state as needed;
- (2) The State will define ways to identify and enroll the State's ethnic minorities e.g., Native Americans, Asian Americans, Hispanics;
- (3) It is not anticipated that the State will need to increase the number of eligibility workers initially. As of January 1, 2005, DOM assumed the responsibility of eligibility determination for MHB. The State expanded the twenty-five regional offices to thirty and deployed over four hundred Medicaid specialists to the thirty regional Medicaid offices as well as over two hundred 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 October 1, 2005, at least 65,000 CHIP enrollees will be maintained in the Program.

Performance Goal for Objective 4:

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

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

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

Performance Goal for Objective 5:

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

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

Performance Goals for Objective 6:

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

9.3. Describe how performance under the plan will be measured through objective, independently

verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

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

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

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

Objective 1:

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

Objective 2:

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

Objective 3:

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

Objective 4:

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

Objective 5:

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

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

Objective 6:

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

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

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well 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)) (42CFR 457.720)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 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)) (42CFR 457.120(c))

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

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

- 9.9.2** For an amendment relating to eligibility or benefits (including cost sharing and

enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(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 #8, effective 07/01/2013.

	Federal Fiscal Year 2014 Oct - Sept Projected Costs
Enhanced FMAP rate	81.14%
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 beneficiary 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)	180,696,132
State Share	44,520,605
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)) (42CFR 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. (42CFR 457.710(e))

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

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)) (42CFR 457.940(b))

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

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

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

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

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

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

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

program)

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

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

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
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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 prepregnancy 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.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. 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.
28. 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.

ATTACHMENT A

Children
Unservd Eligibles

835,021
41,751

DIVISION OF MEDICAID
Unservd Eligibles

PREPARED BY: BP
05/12/91

* - National Average

COUNTY	COUNTY POPULATION under age 19	% of Elig. Children Unservd	No. of Children Potentially Eligible For Medicaid
Adams	11,277	5.00%	564
Alcorn	9,061	5.00%	453
Amite	4,329	5.00%	216
Attala	5,611	5.00%	281
Benton	2,638	5.00%	132
Bolivar	16,194	5.00%	810
Calhoun	4,396	5.00%	220
Carroll	2,920	5.00%	146
Chickasaw	5,974	5.00%	299
Choctaw	3,017	5.00%	151
Claiborne	4,486	5.00%	224
Clarke	5,558	5.00%	278
Clay	7,369	5.00%	368
Coahoma	11,951	5.00%	598
Copiah	9,735	5.00%	487
Covington	5,609	5.00%	280
DeSoto	21,730	5.00%	1,087
Forrest	21,207	5.00%	1,060
Franklin	2,722	5.00%	136
George	5,647	5.00%	282
Greene	3,421	5.00%	171
Grenada	6,945	5.00%	347
Hancock	9,619	5.00%	481
Harrison	51,893	5.00%	2,595
Hinds	81,103	5.00%	4,055
Holmes	8,500	5.00%	425
Humphreys	4,710	5.00%	236
Issaquena	672	5.00%	34
Itawamba	5,761	5.00%	288
Jackson	37,965	5.00%	1,898
Jasper	5,792	5.00%	290
Jefferson	3,366	5.00%	168
Jefferson Davis	4,888	5.00%	244
Jones	19,199	5.00%	960
Kemper	3,560	5.00%	178
Lafayette	9,463	5.00%	473
Lamar	10,028	5.00%	501
Lauderdale	23,836	5.00%	1,192
Lawrence	4,157	5.00%	208
Leake	5,827	5.00%	291
Lee	20,415	5.00%	1,021

Total Children
Unservd Eligibles

835,021
41,751

DIVISION OF MEDICAID
Unservd Eligibles

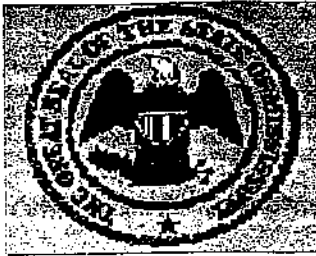
PREPARED BY: BP
05/24/98

* - National Average

COUNTY	COUNTY POPULATION under age 19	% of Elg. Children Unservd	No. of Children Potentially Eligible For Medicaid
Leflore	13,506	5.00%	675
Lincoln	9,583	5.00%	479
Lowndes	19,541	5.00%	977
Madison	17,605	5.00%	880
Marion	8,590	5.00%	430
Marshall	10,311	5.00%	516
Monroe	11,699	5.00%	585
Montgomery	3,915	5.00%	196
Neshoba	8,211	5.00%	411
Newton	6,515	5.00%	326
Noxubee	4,709	5.00%	235
Oktibbeha	12,044	5.00%	602
Panola	10,699	5.00%	535
Pearl River	12,659	5.00%	633
Perry	3,765	5.00%	188
Pike	12,478	5.00%	624
Pontotoc	6,715	5.00%	336
Prentiss	7,097	5.00%	355
Quitman	3,861	5.00%	193
Rankin	26,685	5.00%	1,334
Scott	8,075	5.00%	404
Sharkey	2,873	5.00%	144
Simpson	7,809	5.00%	390
Smith	4,672	5.00%	234
Stone	3,675	5.00%	184
Sunflower	11,866	5.00%	593
Tallahatchie	5,606	5.00%	280
Tate	7,339	5.00%	367
Tippah	5,897	5.00%	295
Tishomingo	4,694	5.00%	235
Tunica	3,411	5.00%	171
Union	6,492	5.00%	325
Walthall	5,016	5.00%	251
Warren	12,275	5.00%	614
Washington	25,425	5.00%	1,271
Wayne	6,759	5.00%	338
Webster	3,075	5.00%	154
Wilkinson	3,267	5.00%	163
Winston	1,304	5.00%	65
Yalobusha	3,751	5.00%	188
Yazoo	9,001	5.00%	450

NOTE: This estimate is not to be taken as definitive. There are too many variables in census data and medical service data to get an accurate estimate of possible medicaid eligibles not now covered. The Heritage Foundation quotes unserved eligibles nationwide at about 6.5%. We believe MS's percentage of unserved eligibles is lower. We estimate 5%.

ATTACHMENT B



Mississippi Division of Medicaid

Run Date: Tuesday July 27, 1999

Run Time: 04:33:55 PM

Current Count of Eligibles
Age 0 - 18 as of July 1, 1999

Elig Month State Aid Categ Desc	Unduplicated Count of Eligibles
02 - SSI/Meds Aid To Blind	60
03 - AFDC;AFDC Related Meds	35,139
04 - SSI/Meds Disabled	23,902
26 - Child Welfare Service (Foster Care)	752
44 - Poverty - Disabled	91
85 - Medical Assistance - Pregnant Women And Children	12,361
87 - Pregnant Women And Children Under 133% Poverty Level	21,145
88 - Pregnant Women And Children Under 185% Poverty Level	4,176
89 - Katie Beckett's	624
91 - Children 10-1-83 Or After; Under 18 Under 100% Poverty	106,737
KK - K-Baby	18,197
Sum:	223,184

Elig Month Recipient Age	Unduplicated Count of Eligibles
0	27,284
1	14,940
2	12,998
3	12,447
4	13,015
5	13,072
6	12,939
7	12,557
8	12,290
9	11,750
10	11,081
11	10,216
12	9,809
13	9,402
14	9,266
15	8,521
16	8,108
17	7,742
18	5,747
Sum:	223,184

Recipient County Desc	Unduplicated Count of Eligibles
001 - Adams	3,465
002 - Alcorn	2,016
003 - Amite	1,145
004 - Attala	1,796
005 - Benton	725
006 - Bolivar, E.	5,291
007 - Calhoun	1,126
008 - Carroll	704
009 - Chickasaw, E.	673
010 - Choctaw	890
011 - Claiborne	1,368
012 - Clarke	1,028
013 - Clay	2,184
014 - Coahoma	5,002
015 - Copiah	2,890
016 - Covington	1,827
017 - Desoto	2,468

Recipient County Desc	Unduplicated Count of Eligibles
018 - Forrest	5,761
019 - Franklin	902
020 - George	1,163
021 - Greene	837
022 - Grenada	2,006
023 - Hancock	2,344
024 - Harrison	10,951
025 - Hinds	19,804
026 - Holmes	4,179
027 - Humphreys	2,021
028 - Issaquena	302
029 - Itawamba	977
030 - Jackson	6,177
031 - Jasper	1,526
032 - Jefferson	1,131
033 - Jefferson Davis	1,576
034 - Jones	4,815
035 - Kemper	811
036 - Lafayette	1,294
037 - Lamar	2,129
038 - Lauderdale	5,491
039 - Lawrence	1,086
040 - Leake	1,401
041 - Lee	4,011
042 - LeFlore	5,651
043 - Lincoln	2,336
044 - Lowndes	5,062
045 - Madison	4,822
046 - Marion	2,708
047 - Marshall	2,411
048 - Monroe	2,615
049 - Montgomery	1,194
050 - Neshoba	2,205
051 - Newton	1,448
052 - Noxubee	1,992
053 - Oktibbeha	2,631
054 - Panola	3,540
055 - Pearl River	3,159
056 - Perry	1,111
057 - Pike	4,017
058 - Pontotoc	1,128
059 - Prentiss	1,323
060 - Quitman	1,659
061 - Rankin	4,010

Recipient County Desc	Unduplicated Count of Eligibles
062 - Scott	2,138
063 - Sharkey	1,360
064 - Simpson	2,244
065 - Smith	1,210
066 - Stone	1,110
067 - Sunflower	5,184
068 - Tallahatchie	1,953
069 - Tate	1,423
070 - Tippah	1,228
071 - Tishomingo	887
072 - Tunica	1,198
073 - Union	1,151
074 - Walthall	1,751
075 - Warren	4,487
076 - Washington	9,866
077 - Wayne	1,876
078 - Webster	742
079 - Wilkinson	1,310
080 - Winston	1,844
081 - Yalobusha	1,240
082 - Yazoo	3,954
083 - Bolivar, W.	1,333
084 - Chickasaw, W.	654
085 -	2
095 - Foster Children	724
Sum:	223,184