

**FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- C Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**
- C Provide *consistency* across States in the structure, content, and format of the report, **AND**
- C Build on data *already collected* by HCFA quarterly enrollment and expenditure reports, **AND**
- C Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

State/Territory:

Mississippi

(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) **Mississippi Health Benefits Program**

SCHIP Program Type _____ Medicaid SCHIP Expansion Only
_____ Separate SCHIP Program Only
X _____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

Mississippi's children health insurance program is entitled MS Health Benefits Program (MHB). MHB is a combination of Medicaid expanded and separate insurance program (CHIP). The Medicaid expanded Phase I was implemented July 1998 covering children 15-18 at 100% FPL. CHIP Phase II started January 01, 2000 covering children age 0-18 years up to 200 % FPL under a separate insurance plan (Blue Cross Blue Shield).

As a coordinated effort between the Governor's Office, State agencies, community health centers, professionals, community and faith-based organizations and advocates, an Outreach and Enrollment Plan was developed. The plan included a massive media campaign, special initiatives with the public school system and community-based, door-to-door outreach and enrollment activities. The massive media outreach campaign was launched April, 2000 initiated with a press conference held by Governor Ronnie Musgrove. The media campaign included radio, television, and newspaper advertisement. This campaign was done to insure that all potentially-eligible families knew of the Program, how and where to apply. In August, 2000 the special initiative with the public school started. For each child enrolled in MS Health Benefits through any public school, the school was paid twenty dollars (\$20). In June coordinated with Children's Defense Fund and supported by the community at large, a state-wide outreach and enrollment campaign took place. This event consisted of out-stationed enrollment stations being set up at grocery stores, K-Mart, WalMart, malls and day care centers. The Department of Human Services, the state agency that determines eligibility, was opened extended hours at designated locations.

5. Eligibility determination process N/C

6. Eligibility redetermination process N/C

Due to poor response to two re-certification notices, the State is considering passive certification.

7. Benefit structure N/C

This sections has been designed to allow you to report on your SCHIP program-s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter N/C=for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility

CHIP Phase II of MS Health Benefits Program (a separate health insurance plan) was approved to increase income eligibility to 200% FPL in December 1999 and implemented January 01, 2000. This meant an estimated 85,000 uninsured children under age 19 would become eligible for health coverage.

Proof of age was eliminated. Self-declaration of age was implemented October 2000. Copies of birth certificates or any other birth records on applicants is no longer required to accompany completed applications. Securing these records as well as coping these materials was a viewed as a burden on the applicants.

2. Enrollment process N/C

3. Presumptive eligibility N/C

The State is discussing the implementation of presumptive eligibility by summer 2001.

4. Continuous eligibility N/C

5. Outreach/marketing campaigns

Coordinated with Catholic Charities' Children's Health Matters, four regional training sessions on the application process and barriers was held across the State. These trainings were held to provide training and an update on the application process for health/social service agencies and other interested parties. Mississippi was one of two states to partake in the HCFA Outreach Initiative with Historically Black Colleges to focus on CHIP and dual Medicaid-Medicare outreach to Afro-Americans in rural areas.

No benefit change occurred, but an increase in limited dental coverage under the Phase II Plan is being considered. The Plan primarily covers preventive dentistry such as tooth-fillings and cleaning. Other dental care is covered if it is warranted as a result of an accident or a medically-associated diagnosis. A number of dentists and consumers have expressed great

concern since most of the children seen need more treatment before they can put on a preventive, maintenance plan.

6. Cost-sharing policies

There has been no change in cost-sharing policies since implementation in of CHIP in January 2000. There are no premiums or deductibles. Families with income less than 150% FPL have no co-pay. For families with income greater than 150% FPL up to 175% FPL, there is a five dollar (\$5) co-pay for office visits and \$15 for emergency room visits with a \$800 maximum out-of-pocket/calendar year. Families with income greater than 175% FPL - 200% FPL also have the same \$5 and \$15 co-pays and \$950 maximum out-of-pocket per calendar year. There are no copayments American Indian and Alaskan native families. There are no copayments for preventive services. Cost sharing polices are communicated to families through information provided by the insurer i.e., the Member Booklet and identification card.

7. Crowd-out policies

Under the CHIP plan, the six month waiting for children with previous creditable health insurance was eliminated in October, 2000. The Program currently has a zero waiting period meaning that the applicant must be without other health insurance at the time of application. The State must monitor the number of children enrolled since the policy change who have had health insurance coverage in the last six months. When that number is 15% of the enrollment, the State will implement a new waiting period with defined exceptions.

8. Delivery system N/C

9. Coordination with other programs (especially private insurance and Medicaid)

The same application is used to apply for Medicaid and CHIP. The same eligibility worker tests the application for Medicaid eligibility first. If in-eligible for Medicaid, the application is screened for CHIP eligibility.

10. Screen and enroll process N/C

11. Application

The application for MS Health Benefits was revised to eliminate non-essential questions, simplified, and more visually appealing.

12. Other

1.2 Please report how much progress has been made during FY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FY 2000. Describe the data source and method used to derive this information.

It was originally estimated that 15,000 un-insured children would be eligible for Medicaid expanded and 85,000 for CHIP. From the reviews of the Division of Medicaid (DOM) data and enrollment data from the Department of Human Services (DHS), more children are being determined eligible for Medicaid; consistently at a ratio of 2:1, as high as 4:1 at other times. As of August 2000, there were 219,633 children covered by Medicaid processed through DHS reflecting a gain of 70,862 children from July 1998 (for Medicaid only and 10,416 Medicaid expanded). There was an additional 13,814 enrolled in CHIP.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

During FY 2000, the number of children ever enrolled in Medicaid expanded was 12,156 and 10,085 were eligible as of 09/30/00. For CHIP II, the number of children enrolled was 16,179. This data was obtained from enrollment data from DOM and DHS.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

As previously stated, uninsured children enrolled in the general Medicaid programs has increased tremendously since MHB started in July 1998.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

No, skip to 1.3

Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

*Note: If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter **ANC@**(for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		

Table 1.3		
<p>Reduce the percentage of low-income children without health insurance coverage.</p>	<p>By July 1, 1998, the capacity within DOM and DHS will be appropriately expanded or modified to meet the target of enrolling approximately 15,000 children in year one of MS's Phase I. These areas will include data systems modification, eligibility determinations, enrollment, participation information, health service utilization, billing, health status, provider information, personnel, staff training, publications and documents.</p>	<p>Data Sources: Division of Medicaid and Department of Human Services (DHS) data management systems</p> <p>Methodology: Information is based an interval review of the agencies data systems and enrollment reports generated from applications processed thru September 30, 2000.</p> <p>Progress Summary: As of September 30, 2000 , 28,329 applications for MHB had been and approved for health benefits. Some system modification and enhancement have been implemented to expedite the enrollment process and eliminate the loss of Medicaid benefits for children in closed or sanctioned TANF cases. Other system upgrades are in the progress. At least three statewide staff training sessions were conducted during FY 2000. A new more appealing application, application/brochure has been developed along with a number of specialty items (bags, pencils, magnets, book covers, etc.). The county DHS offices, DOM Regional Offices and the county health department clinics are used as distribution sites for the public to obtain MHB materials.</p>
OBJECTIVES RELATED TO SCHIP ENROLLMENT		

Table 1.3		
<p>Enroll all eligible children in MHB</p>	<p>Outreach activities will be re-evaluated and materials developed and distributed statewide by 07/1/2000. Defined outreach activities will be implemented to target and enroll ethnic minorities. For CHIP, the contractor will provide similar education and outreach.</p>	<p>Data Sources: DOM and DHS</p> <p>Methodology: Number of children enrolled as reported from enrollment data reports on June 30, 2000.</p> <p>Progress Summary: 10,416 children were enrolled in Medicaid expanded as of June 30, 2000; 10,112 children were enrolled in CHIP. As far as outreach, the state implemented a statewide mass media blitz including ads on television, tv and in newspapers and specialty publications. The newly produced application and flyers was distributed statewide to health department and community health clinics, other health and child care providers, churches, and social service agencies. The application is also available in Spanish. In August 2000, a special incentive outreach initiative with the public school system was started where the schools are paid \$20/children enrolled in Medicaid or CHIP. Data from the schools' application for free or reduced meals is used to identify families needing health insurance for their children. Also in August, Mississippi was one of the states selected to participate in an outreach and enrollment initiative with Historically Black Colleges and Universities focused on reaching Afro-Americans in rural areas. The application process was simplified requiring less documentation. Ongoing trainings and presentations are provided to the public upon demand. Training on the application process has been provided for the staff at the Indian reservation. Two eligibility workers assist with the process onsite. For CHIP, the contractor has staff assigned to assist with provider education and recruitment. All members enrolled receive a beneficiary package that includes their card, provider network and benefits booklets.</p>

Table 1.3

OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT

<p>Increase the number of Medicaid-eligible children enrolled in Medicaid.</p>	<p>By July 01, 1999, 12,000 previously uninsured, low-income children will have health insurance coverage under Medicaid. By January 1, 2000, 35, 000 children will be assessed for CHIP and 30,000 enrolled.</p>	<p>Data Sources: DOM and DHS data management system</p> <p>Methodology: Number of children receiving Medicaid benefits reported as of July 1, 1999 and September 30, 2000.</p> <p>Progress Summary: As of July 2000 10,416 were enrolled in Medicaid expanded; CHIP was implemented January 1, 2000 with 503 enrolled. As of 07/98, 182,198 children under age 19 were enrolled in Medicaid. As of September, 2000 this number had increased to 243,837 (excluding children enrolled in MHB). That is an increase of 61,639.</p>
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OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)

Table 1.3		
<p>Ensure all children enrolled in MHB have access to health care.</p>	<p>By July 1, 1999 85% of children enrolled in Medicaid expanded will have a medical home.</p>	<p>Data Sources: DOM, DHS and Department of Finance Administration (DFA)</p> <p>Methodology: Claims data is crossed-matched with the list of enrolled children.</p> <p>Progress Summary: HealthMacs, a form of managed care, is mandatory for Medicaid-enrolled children. When a children is approved for Medicaid, the children is assigned to a primary care provider. As of FY 2000, 85% of the total Medicaid population had been assigned to a primary care provider.</p> <p>From January 1, 2000 - September 30, 2000 over 16,000 children had health coverage under CHIP. These children had access to providers throughout the state. Services were delivered through a fully insured health plan with a commercial network of providers. One hundred percent (100%) of enrolled children had access to a primary care provider within 15 miles for urban/suburban areas and 93.4% access for a pediatric provider within 25 miles for rural areas. A vision network was established in April, 2000 for routine vision services. Access is approximately 99% for an optometrist within sixty miles. Efforts are continuing to expand this network for optimal access in all areas. Monitoring of provider access is ongoing.</p>
<p>OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)</p>		

Table 1.3		
<p>MHB will improve the health status of children enrolled in the Program.</p>	<p>The State will conduct ongoing reviews of age specific utilization data that will be used to monitor the progress of established performance goals of the target population</p>	<p>Data Sources: DOM, and DFA</p> <p>Methodology: MS's Management Information Retrieval System (MMIRS) will provide on-line, age specific utilization data on MBH Medicaid expanded. DFA will be responsible for securing likewise utilization data from the Contractor</p> <p>Progress Summary: Relative to Medicaid enrollees, dental utilization has increased. More enrollees are receiving dental services as well as services are provided per enrollees. Infants enrolled in the high-risked case management program, about 57% received the EPSDT screening.</p> <p>Relative to the CHIP enrollees, detailed analysis of data is not available at this time. The State is in the process of finalizing a contract with a data management vendor to integrate CHIP data into a decision support system. This system will allow for more detailed analysis of encounter data. Preliminary encounter data indicate the following: an average monthly enrollment of 6,822 for all federal poverty levels up to 200% for the period January - September, 2000. Listed below are rates for some key measures/rate per 1000members: inpatient hospital admits - 21.4; outpatient hospital - 427.44; ER visits - 63.03; Outpatient physician services - 1892.26; dental services - 881.27. The number of prescriptions per member is 3.72.</p>
<p>OTHER OBJECTIVES</p>		

		Data Sources: Methodology: Progress Summary:
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1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Performance Goal for Objective 3 was not met. CHIP II was not implemented until January 01, 2000. As applications are processed, they are screened first for Medicaid eligibility then if ineligible for Medicaid, then CHIP eligibility. Applications have consistently been approved at a ratio of 2 Medicaid to 1 CHIP. The general Medicaid population has shown a tremendous increase in enrollment as well.

Performance Goal for Objective 5 was not met to the fullest. The HEDIS 3.0 measures that was run for the capitated managed care HMO pilot has been discontinued. The state no longer has any operating HMOs. The customizing of MMIS to particularly identify the desired target for the specific measures is not complete. The contact with a data management vendor to integrate CHIP data into a decision support system has not been finalized.

1.5 Discuss your States progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

The employer-subsidized insurance plan was approved but is on hold with no defined implementation date. The preliminary reviews conducted by an actuary indicated that the number of families that may benefit from this plan was minimum and the administration could be very costly per beneficiary.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Future performance measurement activities include: (a) A review of immunization compliance, initially, in the less than 36 month old populations. The review should take place in the first quarter of 2001. (b) More detailed analysis of claims data will take after first quarter 2001. Detailed analyses will include, but not limited to, utilization of preventive services— age ranges, frequency, etc., top diagnosis, frequencies of hospital admissions/readmissions, utilization of allied health services and other standards of care indicators. (c) A Member Satisfaction Survey is being conducted in December 2000. Results from this survey should be available in March 2001. (d) There will also be continued monitoring of provider access.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program-s performance. Please list attachments here. (Member Satisfaction Survey)

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults N/A

Number of children N/A

3. How do you monitor cost-effectiveness of family coverage?

N/A

2.2 Employer-sponsored insurance buy-in:

The employer-sponsored insurance buy-in has not been implemented at this time. No date for future implementation is available.

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of adults

Number of children

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

Crowd-out is defined as instances where the number of children enrolled in MHB who have had previous creditable health is 15% of the total enrollment since 10/1/2000.

2. How do you monitor and measure whether crowd-out is occurring?

To prevent crowd-out, the CHIP plan had a six-month waiting period for children who have been covered by a creditable health insurance plan in the last six months. The State was monitoring the number of applications denied due to previous coverage. The State had no data to substantiate the continuance of the waiting period. Elimination of the waiting period had such statewide support that a bill was passed and signed by the Governor to eliminate or seek the least restrictive waiting period per HCFA approval. Consequently, the six month waiting period was eliminated October 01, 2000 and zero waiting period implemented. The State is monitoring on a monthly basis the number of children enrolled who have had insurance coverage in the last six months. When the number enrolled who have had coverage in the last six months equals 15% of the total enrollment since 10/01/00, the State will explore implementing a crowd-out provision such as waiting period with some exceptions. Meanwhile the State will conduct a survey of the children identified who have had coverage in last six months to determine the reason for lost or dis-continuance of coverage. The results from the survey will be used to identify the possible exceptions to the waiting period.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

The state's economy has had a significant impact on the insured population. Several major companies closed operations in the State. A large number of workers lost their jobs as well as their health insurance coverage. Furthermore, other employers (state employees included) were experiencing tremendous increases in health insurance premiums to the point, in many cases, where they could no longer provide or afford dependent coverage. This information is based the monitoring of calls received and contacts made with various businesses, affected employees, and employers.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

The six month waiting that was in effect until 10/1/00 was viewed as a barrier for families who met all other eligibility criteria but choose to make sacrifices to pay the premiums for dependent health insurance coverage. It was also effective in preventing substitution of coverage.

2.4 Outreach:

- A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Providing train the trainer sessions statewide open to the public on the application process has been the most effective outreach effort. Through these sessions, a vast number of individuals, groups, organizations, health and social service providers that provide services to children are trained on completing the application, the eligibility criteria, benefits, and resources for help and complaints.

Effectiveness is measured based manually and systematically monitoring application distribution and completed application outcome.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Two out-stationed eligibility workers are assigned to the Indian Reservation to complete applications on-site. Targeted on-site sign-up events have been effective reaching the selected group. Mississippi also participated in the outreach and enrollment initiative with Historically Black Colleges and Universities where Afro-Americans in rural areas were the target.

Monitoring the distribution of applications, completed applications and outcomes are component of quality management.

3. Which methods best reached which populations? How have you measured effectiveness?

On-site sign-up events at work sites has been most effective in reaching the working parents. Utilizing data from the schools free and reduced meals applications has been helpful in identifying the potential target among the public school population.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

The State Plan has a 12-month continuous eligibility. We also exploring the concept of passive re-certification.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?
- Follow-up by caseworkers/outreach workers
- Renewal reminder notices to all families
- Targeted mailing to selected populations, specify population _____
- Information campaigns
- Simplification of re-enrollment process, please describe _____
- Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe _____
- Other, please explain _____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.
- Yes**

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Beyond the 12 month continuous eligibility, current methods have not proven to be effective. After two reminder notices, the response rate is low. The State is exploring the implementation of passive re-determination.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

No information available.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

A common application is used to determine eligibility for both programs and processed by the same entity (same eligibility worker). The program also use the same re-determination process for CHIP and Medicaid.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

When an application is processed at re-determination, if the family's income is over the limit for Medicaid, it is then assessed for CHIP eligibility.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

No, all Medicaid providers are not CHIP providers; all CHIP providers are not Medicaid providers. Medicaid recipients are assigned to primary care providers. CHIP beneficiaries are provided a network of providers.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

There are no premiums or enrollment fees for participation in CHIP.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

No assessment has been conducted on the effects of cost-sharing on utilization of health services under SCHIP. There are no copayments on preventive services (well child), vision and hearing services, and immunizations. It is not anticipated that the minimal copayments of \$5 and \$15 have had an impact on utilization of services. Further analyses of copayments will be available after information has been integrated into the decision support system.

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

DOM does capture service utilization data on enrollees. On site records reviews are conducted with providers.

Information on quality of care for CHIP enrollees is not yet available. Once data from the Program's first year of operation can be integrated into the data management system the State will examine the quality indicators that can be measured in a Fee for Service delivery system, e.g. utilization of preventive services.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

MMIS does capture service utilization data on enrollees. The system is being customized to focus on identifying the SCHIP enrollees relative to selected service categories.

The Governor's Office, DHS, DOM, DFA, and the insurer's customer service department receive telephone calls, written correspondence, etc. from enrollees, providers, those denied enrollment and others regarding access, quality, structure, eligibility, etc. All concerns/issues are addressed on an individual basis with appropriate interventions as indicated. To date, no unfavorable quality issues have been identified.

From the insurer, the customer service received approximately 22,000 calls during the first three quarters of year 2000. The insurer received 30 appeals; 12 were upheld and 18 overturned. Ninety percent of the appeals received were related to out-of-network and non-covered services.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The state is in the process of establishing an outside contract with a private organization to be a complete evaluation of the program's outreach and enrollment activities that will include surveying the enrollees and those potentially eligible but not enrolled.

Once detailed analyses of claim data become available, the State will identify and target areas for improvement. It is anticipated that some of this detailed data will be available after the first quarter of 2001. Implementation of a system of follow up on those children identified who have not had a visit with a health care provider in a standard period of time, based on age, is planned for 2001. Program interventions/implementation may also be driven by data on top diagnoses for hospitalizations and acute care identified in this population. Information from the Member Satisfaction Survey will be used to assess quality of care issues as well.

- 4.

SECTION 3. SUCCESSSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter >NA=for not applicable.

1. Eligibility

The documentation required to be submitted i.e., proof of age, proof of income with a completed application was viewed on a barrier. As of 10/1/00, proof of age was no longer required. The State is exploring options available to verify income in lieu of requesting proof of income from the applicants.

2. Outreach

Lack of sufficient staff relying heavily on others to carry-out outreach activities is a constraint. The CHIP staff consisted of the program coordinator and an assistant. The CHIP Outreach Coordinator was not hired until Feb/2000 and the assistant in June.

3. Enrollment

Issues relative to child support associated with the application has been a deferent to some applying or following through with the application process. Re-fresher training has been provided for the county eligibility workers to issue that no eligible children will denied due to parents' refusal to cooperate with child support and to re-enforce that information re the absent parent was not necessary to process applications on children.

4. Retention/disenrollment N/A

5. Benefit structure

Dental benefits under CHIP are limited primarily to preventive care unless medically necessary or if dental care needed is as a result of an accident. This will possibly be the first area of benefit expansion.

6. Cost-sharing

N/A

7. Delivery systems

Access to vision and dental providers in selected areas is limited. The State is exploring others initiatives to recruit and retain providers including conducting provider surveys.

8. Coordination with other programs

Children with special needs are referred to the Department of Health Children's Medical and First Step Programs.

9. Crowd-out

The six-month waiting period for those with previous health coverage was viewed as a barrier to enrollment rather than a crowd-out mechanism. The six month period was without exceptions. The six-month waiting was reduced to zero with some monitoring requirements.

10. Other

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments	7,721,626	52,000,000	55,000,000
Managed care			
per member/per month rate X # of eligibles			
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs			
Administration Costs			
Personnel			
General administration	987,391	3,000,000	3,000,000
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs	459,241	2,000,000	2,000,000
Other			
Total Administration Costs			
10% Administrative Cost Ceiling	2,223,487	5,700,00	6,000,000
Federal Share (multiplied by enhanced FMAP rate)	7,679,333	47,743,000	49,956,000
State Share	1,488,925	9,257,000	10,044,000
	9,168,258	57,000,000	60,000,000

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

N/A

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

____ State appropriations

____ County/local funds

____ Employer contributions

____ Foundation grants

____ Private donations (such as United Way, sponsorship)

Other (specify) State of MS, expendable Trust Fund

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures. NO

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		
Provides presumptive eligibility for children	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 3 months	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Makes eligibility determination	<input type="checkbox"/> State Medicaid eligibility staff <input checked="" type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> State Medicaid eligibility staff <input checked="" type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____
Average length of stay on program	Specify months <u>12 continuous eligibility</u>	Specify months ____ <u>12</u>

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over phone	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>Uninsured at the time of application</u> What exemptions do you provide? None
Provides period of continuous coverage <u>regardless of income changes</u>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>12</u> Explain circumstances when a child would lose eligibility during the time period	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>12</u> Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information precompleted and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

At the time of redetermination, the applicant is not required to complete a new application, but is required to provide proof of income, and report any changes in family status (household size, child care expenses or receiving child support as a part of income).

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or
Section 1931-whichever category is higher

_185% of FPL for children under age **_1_**
133_% of FPL for children aged **_1-6 yrs_**
_100% of FPL for children aged **___6-15 yrs**

Medicaid SCHIP Expansion

100% of FPL for children aged **15-19 yrs**
____% of FPL for children aged _____
____% of FPL for children aged _____

State-Designed SCHIP Program

200% of FPL for children aged **_0-19 yrs**
____% of FPL for children aged _____
____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and amounts of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter N/A.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) Yes No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	\$90/parent	\$90/parent	\$90/parent
Alimony payments Received	\$	\$	\$
Paid	\$	\$	\$
Child support payments Received	\$50	\$50	\$50
Paid			\$
Child care expenses	\$200/ child under age 2; \$175/adult or child over age 2	\$200/ child under age 2; \$175/adult or child over age 2	\$200 under age 2; \$175/adult or child over age 2
Medical care expenses	\$	\$	\$

Table 6.2			
Other types of disregards/deductions (specify)	\$	\$	\$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups No Yes, specify countable or allowable level of asset test _____

Medicaid SCHIP Expansion program No Yes, specify countable or allowable level of asset test _____

State-Designed SCHIP program No Yes, specify countable or allowable level of asset test _____

Other SCHIP program _____ No Yes, specify countable or allowable level of asset test _____

6.4 Have any of the eligibility rules changed since September 30, 2000? Yes No

The FPL was increased to 200% FPL in January, 2000.

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage N/A
2. Employer sponsored insurance buy-in N/A
3. 1115 waiver
4. Eligibility including presumptive and continuous eligibility

Plans are underway to implement presumptive eligibility by April, 2001.

5. Outreach

Statewide grass-root outreach and enrollment blitz is planned for April, 2001.

Expand financial incentive to other child service providers such as Head Start centers occurred in January, 2001.

6. Enrollment/redetermination process

Implement passive re-determination.

7. Contracting

Establish a contract with an outside provider to be an evaluation of MHB.

8. Other