

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

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

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

The following State Evaluation is submitted in compliance with Title XXI of the
Social Security Act (Section 2108(b)).

(Signature of Agency Head)

Date 04/07/00

Reporting Period 07/01/98 - 09/30/99

Contact Person/Title Maria D. Morris / MS Division of Medicaid, CHIP Coordinator

Address 239 North Lamar Street, Suite 801, Jackson, MS 39201-6048

Phone (601) 359-4294 Fax (601) 359-6048

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

- 1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

Based on estimates from the Hertiage Foundation combined with the State's estimates, there are 15,000 children ages 15 through 18 in the State who are eligible for Mississippi Health Benefits Phase I. These children are not eligible for Medicaid under Title XIX nor can afford creditable health care coverage through any other program i.e., State and Public School Employees' Health Insurance.

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

The estimated baseline number of 15,000 was generated based on reports generated by the Division of Medicaid's decision support system, MMIRS. It determined that an average of 5000 new recipients in age group could become eligible looking at the age group just below this age group i.e., the 12-14 year olds.

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

The baseline estimates 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%. It is believed that percentage in Mississippi is lower - 5%.

- 1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

The first phase of the Mississippi Title XXI Program, Mississippi Health Benefits Program, was approved October 26, 1998 with an effective date of July 01, 1998. Phase I expanded Medicaid coverage to children ages 15 through 18 in families with incomes below 100% of the Federal Poverty Level (FPL). Based on Heritage Foundation and Urban Institute estimates as well as the State's own estimates, there are 15,000 children ages 15 through 18 in the State who are eligible for Mississippi Health Benefits Phase I. These children are not eligible for Medicaid under Title XIX. In July 1998 when Phase I was implemented, there were 65,500 children to age 15 covered in the 100% poverty level group for children. As of 10/99, 84,953 children were covered in this same program now up to age 19. Eleven thousand of the target 15,000 children are now covered. During this time frame, there has been a 29,888 increase in the number of children enrolled in the poverty level program alone. As of 10/99 children age birth to age 19 participating in Medicaid and certified by DHS was 189,232 whereas in 07/98 for the same age that number was 148,771. The significant increase in all Medicaid programs including Phase I reflects that children are being enrolled that were already Medicaid eligible, but not enrolled.

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

1.2.2 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.)

The data is derived from the reports generated by the Division of Medicaid's decision support system, Mississippi's Management Information Retrieval System (MMIRS) as supplied from eligibility determination by the Department of Human Services.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Table 1.3 has been completed to summarize Mississippi's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan.

Column 1: List the State's strategic objectives for the CHIP program, as specified in the 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.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings

to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Objective I: To reduce the percentage of low-income children without health insurance coverage.

Progress:

It is estimated that 15,000 uninsured children could be affected by CHIP Phase I. Eleven thousand of the estimated target are now enrolled. In July 1998, when CHIP I was implemented, there were 65,000 children to age 15 covered at the 100% poverty level. As of 12/99, 134,857 children were covered in this same program now up to age 19. There has been a 69,157 increase in the number of children covered in the poverty level program. As a result of CHIP Phase I outreach activities, children that should have already been covered under Medicaid are now being enrolled as well.

Objective II: To enroll all eligible children in MS Health Benefits Program.

Progress:

The performance goal is to enroll 10,000 children by 07/01/99 in MS Health Benefits Program Phase I and enroll 30,000 children by 07/01/2000 in Phase II. By Quarter ending 06/30/99, 8034 children were enrolled in Phase I; Quarter ending 09/30/99, 10,872 and 11,223 by quarter ending 12/30/99.

Note: It was discovered in February 2000, the eligibility month fields were being updated when a retro eligibility segment was added. Therefore, new reports had to be run to capture this lost data. Consequently, these numbers need to reflect this corrective measure. The corrective reports will be available by the end of April.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Reduce the percentage of low-income children without health insurance coverage	By July 1, 1999, 10,000 previously uninsured low-income children will have health insurance coverage at 100% FPL.	<p>Data Sources: Division of Medicaid (DOM) and Department of Human Services (DHS)</p> <p>Methodology: Data based on the State's actual enrollment data reports generated from applications processed from July 1998 thru July 1999..</p> <p>Numerator: Number of children enrolled as July 1998</p> <p>Denominator: Number of children enrolled as July 1999</p> <p>Progress Summary: In July 1998, 84,953 children ages 6 through 18 were certified Medicaid eligible under 100% FPL. A year later 109,871 children in this same age group were enrolled in Medicaid reflecting an increase of 24,918 in enrollment.</p>
OBJECTIVES RELATED TO CHIP ENROLLMENT		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
Enroll all eligible children in MS Health Benefits Program	Enroll 10,000 children by 07/01/99 in MS Health Benefits Phase I. Enroll 30,000 children by 07/1/2000 in Phase II.	<p>Data Sources: DOM and DHS</p> <p>Methodology: Number of children enrolled as reported by data system on July 01, 1999</p> <p>Progress Summary: July 1, 1999 an additional 24, 918 children ages 6-18 have been enrolled under Phase I Medicaid expanded.</p> <p>Phase II was implemented January 1, 2000. As of 01/1/2000, about 503 children were enrolled.</p>
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
Increase number of Medicaid-eligible children enrolled in Medicaid	By July 1, 1999 at least 10,000 uninsured children will have health insurance coverage under Medicaid.	<p>Data Sources: DOM and DHS</p> <p>Methodology: Using system data, monitor the Number of children enrolled in the Medicaid Program.</p> <p>Progress Summary: In July 1998, 148,771 children under age 19 years were enrolled in the Medicaid Program. July 1999 this number had increased to 182,198 reflecting an overall increase of 33,427 in enrollment.</p>
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
Ensure all children enrolled in MS Health Benefits have access to health care	By July 1,1999, 85% of children enrolled in MS Health Benefits Phase I (Medicaid expanded) will have a medical home.	<p>Data Sources: DOM and DHS</p> <p>Methodology: Claims data is cross-matched with that the listing of enrolled children to identify primary care provider.</p> <p>Progress Summary: HealthMacs, a form of managed care, has been implemented statewide. All receipts enrolled in Medicaid is cross-matched to identify their usual source of care. To date, 85% of the total Medicaid population has been assigned to a primary care provider.</p>
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:
OTHER OBJECTIVES		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

(X) Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: Mississippi Health Benefits
Program Phase I

Date enrollment began (i.e., when children first became eligible to receive services): Phase I July 01, 1998

Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: Mississippi Health Benefits Program Phase II

Date enrollment began (i.e., when children first became eligible to receive services): January 1, 2000.

Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

Other - Employer-sponsored Insurance Coverage

Name of program: MS Health Benefits Phase III

Date enrollment began (i.e., when children first became eligible to receive services): Projected date 01/01/2001

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Mississippi's employer-sponsored insurance is not expected to be implemented until January 2001. For eligible children in families with access to employer-sponsored health insurance, the Plan will pay the insurance premium for coverage under the employer's plan if the plan meets the following criteria:

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

The State 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. Children who qualify for payment of premiums under an employer-sponsored plan will receive "secondary" or wrap-around" supplemental coverage under MS Health Benefits plan to cover deductibles, co-insurance, co-payments, and pre-existing conditions.

2.2 What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Mississippi Health Benefits Program Phase I is an expansion of the current Medicaid Program extending Medicaid coverage to teenagers age 15 through 18 in families with income under 100% FPL. Phase II was designed to be a state separate insurance program covering children from families with incomes below 133% FPL originally, but was later increased to 200%. There was no pre-existing program to cover this group of children.

2.2.2 Were any of the preexisting programs “State-only” and if so what has happened to that program?

No pre-existing programs were “State-only”

One or more pre-existing programs were “State only” ! Describe current status of program(s):
Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that “affect the provision of accessible, affordable, quality health insurance and healthcare for children.” (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

Changes to the Medicaid program

- Presumptive eligibility for children
- Coverage of Supplemental Security Income (SSI) children
- Provision of continuous coverage (specify number of months 12)
- Elimination of assets tests
- Elimination of face-to-face eligibility interviews
- Easing of documentation requirements

Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)
An estimated 30,000 - 40,000 children in error lost medical assistance when parents were sanctioned. To actually identify this population a cross-match with 1996 active medical assistance cases and current medical assistance was performed in March, 2000. Over 40,000 children in 30,000 household were identified. Letters and applications for MS Health Benefits were mailed to all identified households.

Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- Health insurance premium rate increases
- Legal or regulatory changes related to insurance
- Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- Changes in employee cost-sharing for insurance
- Availability of subsidies for adult coverage
- Other (specify) _____

Changes in the delivery system

- Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

The State implemented a pilot Medicaid capitated managed care program in six counties. This was an option available to children enrolled CHIP Phase I. As of 10/99, all four HMOs had discontinued the provision of services. Mississippi did not prove to be a viable market for the HMOs that were in operation

- Changes in hospital marketplace (e.g., closure, conversion, merger)

- ___ Other (specify) _____
- ___ Development of new health care programs or services for targeted low-income children (specify) _____
- ___ Changes in the demographic or socioeconomic context
 - ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____
 - ___ Changes in economic circumstances, such as unemployment rate (specify) _____
 - ___ Other (specify) _____
 - ___ Other (specify) _____

Narrative Comments:

To encourage families to enroll their children, the State has done the following:

- **Reduce barriers to participation by using the same simplified, “short form” to apply to determine eligibility for Medicaid and CHIP.**
- **Streamlined the income verification process requiring verification of a typical month’s income for custodial parents and child only.**
- **Dispensed resource and asset tests for children.**
- **Widely disseminated the applications that can be mailed in.**

According to State Medicaid data, it was estimated that 30,000 - 40,000 children lost Medicaid coverage in error when parents enrolled in TANF were sanctioned . Therefore, much attention was given to identifying and re-instating medical assistance to these children. System changes are being put in place whereas when cases are closed due a TANF related issue, medical assistance cases are automatically opened for the children in those families.

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

- 3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter “NA.”

Table 3.1.1			
	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide	Statewide	
Age	15 - 18 years	Birth - 18 years	
Income (define countable income)	100% FPL	100 - 200% FPL	
Resources (including any standards relating to spend downs and disposition of resources)	N/A	N/A	
Residency requirements	Must be a US citizen	Must be US citizen	
Disability status	N/A	N/A	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	N/A	Can not have had full private health coverage within the last 6 months	
Other standards (identify and describe)_____			

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Monthly			
Every six months			
Every twelve months	X	X	
Other (specify)_____			

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

Yes No Which program(s)? Both

For how long? 12 months

No

3.1.4 Does the CHIP program provide retroactive eligibility?

Yes No Which program(s)? Phase I Medicaid Expanded

How many months look-back? 3 months

No

3.1.5 Does the CHIP program have presumptive eligibility?

Yes No Which program(s)? _____

Which populations? _____

Who determines? _____

No

3.1.6 Do your Medicaid program and CHIP program have a joint application? YES

Yes Is the joint application used to determine eligibility for other State programs? If yes, specify. _____

No _____

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Mississippi's eligibility determination process allows the applicant to complete a simplified, mail-in application accompanied by a typical month's income and proof age for those applying for benefits. No face-to-face interview is required. Applications are available at each local county department of human services, county health departments, community health centers, Head Start centers, and various other locations. Trained staff are available at each of these locations to assist families with the completion of the application. Completed applications are mailed to the local county department of human services in which the applicant lives for eligibility determination.

Strengths of the eligibility determination process are as follows: (1) a single application is used to apply for either Phase I or Phase II. (2) the application has been simplified - easier read and understand; (3) the application is a mail-in form not requiring a face-to-face interview; (4) verification required has been reduced to a typical month's income and proof of age for applicants; (5) only the income of the custodial parents and applicant is used as countable income; (6) eligibility is determined annually. Eligibility workers are reporting very few instances of incomplete applications.

Weakness of the eligibility determination process is centered around no face-to-face interview required. The department of human services provides a several other supportive services to families. In face-to-face interviews the workers can screen the families for additional services that they may need.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The strengths of the eligibility redetermination process are: (1) redetermination is on an annual basis, (2) no face-to-face interview is required. One page re-determination form is 45 days prior to expiration of benefits requiring verification of current income and update on any changes in household composition or status and (3) This process requires less time on the part of the worker.

The weaknesses of this process are: (1) a significant numbers of redetermination notices are not returned. Consequently, large number of potential eligibles are losing their benefits. (2) With eligibility being determination on an annual basis, addresses of beneficiaries are not always current. (3) No face-to-face interview again is a missed opportunity to educate the beneficiaries on other services.

3.2 What benefits do children receive and how is the delivery system structured?
(Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost-sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 3.2.1 CHIP Program Type Phase I Medicaid Expanded

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	b		
Emergency hospital services	b		
Outpatient hospital services	b		
Physician services	b		
Clinic services	b		
Prescription drugs	b		
Over-the-counter medications			
Outpatient laboratory and radiology services	b		
Prenatal care	b		
Family planning services	b		
Inpatient mental health services	b		

Table 3.2.1 CHIP Program Type Phase I Medicaid Expanded

Benefit	Is Service Covered ? (Y = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Outpatient mental health services	b		Limited to 52 visits annually
Inpatient substance abuse treatment services	b		
Residential substance abuse treatment services	b		Not exceed \$8,000 during a Benefit Period nor \$16,000 in a Lifetime
Outpatient substance abuse treatment services	b		Not exceed \$8,000 during a Benefit Period nor \$16,000 in a Lifetime
Durable medical equipment	b		
Disposable medical supplies	b		
Preventive dental services	b		
Restorative dental services	b		
Hearing screening	b		
Hearing aids	b		Limited to one every three years
Vision screening	b		

Table 3.2.1 CHIP Program Type Phase I Medicaid Expanded

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Corrective lenses (including eyeglasses)	b		Limited to one pair annually
Developmental assessment	b		
Immunizations	b		
Well-baby visits	b		
Well-child visits	b		
Physical therapy	b		
Speech therapy	b		
Occupational therapy	b		
Physical rehabilitation services	b		
Podiatric services	b		
Chiropractic services	b		
Medical transportation	b		

Table 3.2.1 CHIP Program Type Phase I Medicaid Expanded

Benefit	Is Service Covered ? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Home health services	b		
Nursing facility	b		
ICF/MR	b		
Hospice care	b		Limited to an overall lifetime maximum of \$15,000
Private duty nursing			
Personal care services			
Habilitative services			
Case management/Care coordination	b		
Non-emergency transportation			
Interpreter services	b		
Other (Specify) _____ —			

Table 3.2.1 CHIP Program Type Phase I Medicaid Expanded

Benefit	Is Service Covered ? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Other (Specify) _____ —			
Other (Specify) _____			

Table 3.2.1 CHIP Program Type Phase II

Benefit	Is Service Covered ? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	b		
Emergency hospital services	b	\$15 for families with income at 150-200% FPL	
Outpatient hospital services	b		
Physician services	b	\$5 for families with income at 150-200% FPL	

Table 3.2.1 CHIP Program Type Phase II

Benefit	Is Service Covered ? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Clinic services	b		
Prescription drugs	b		
Over-the-counter medications			
Outpatient laboratory and radiology services	b		
Prenatal care	b		
Family planning services	b		
Inpatient mental health services	b		
Outpatient mental health services	b		
Inpatient substance abuse treatment services	b		

Table 3.2.1 CHIP Program Type Phase II

Benefit	Is Service Covered ? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Residential substance abuse treatment services	b		
Outpatient substance abuse treatment services	b		
Durable medical equipment	b		
Disposable medical supplies	b		
Preventive dental services	b		
Restorative dental services	b		Only as a result of accidental injury
Hearing screening	b		
Hearing aids	b		one pair/ 3 years
Vision screening	b		
Corrective lenses (including eyeglasses)	b		One pair of glasses/year

Table 3.2.1 CHIP Program Type Phase II

Benefit	Is Service Covered ? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Developmental assessment	b		
Immunizations	b		
Well-baby visits	b		
Well-child visits	b		
Physical therapy	b		
Speech therapy	b		
Occupational therapy	b		
Physical rehabilitation services	b		
Podiatric services	b		
Chiropractic services	b		
Medical transportation			
Home health services	b		

Table 3.2.1 CHIP Program Type Phase II

Benefit	Is Service Covered ? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Nursing facility	b		
ICF/MR	b		
Hospice care	b		
Private duty nursing			
Personal care services			
Habilitative services			
Case management/Care coordination			
Non-emergency transportation			
Interpreter services	b		
Other (Specify) _____ —			

Table 3.2.1 CHIP Program Type Phase II

Benefit	Is Service Covered ? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Other (Specify) _____ —			
Other (Specify) _____			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Health coverage under MS Health Benefits provides services for children such as screenings that include vision, dental and hearing exams; preventive health care such as immunizations; inpatient and outpatient hospital care; doctor's or clinic visits for well-child checkups and sick-child care; lab services, prescription medicine; eyeglasses and hearing aids. Inpatient and outpatient mental health and inpatient and outpatient substance abuse services are covered. There are no exclusions for pre-existing conditions. Therefore, the full array of comprehensive services are provided to all enrolled children regardless to any special health care needs or conditions. In instances where children with special needs require services not covered by MS Health Benefits, referrals are made to the Mississippi State Department of Health's First Steps Early Intervention Program and the Children's Medical Program or the Department of Vocational Rehabilitation.

Enabling services such as non-emergency transportation, home visits, and case management services are available to the Phase I recipients. Outreach materials are available in Spanish. Interpretators are also available to assist with the application process and delivery of services for Hispanics as well Vietnamese.

There are no cost-sharing requirements for families with income below 150% FPL. There is no cost-sharing for American Indian / Alaska native children. There is also no co-pay for preventive services, including immunizations, well-child care routine preventive and diagnostic dental services, routine dental fillings, routine eye examination and eyeglasses, and hearing aids.

For families with income between 150-175% FPL, there is a co-pay of \$5 for outpatient health care professional visit and \$15 for emergency room visit with a maximum out-of-pocket of \$800/calendar year. Families with income between 176-200% FPL have the same co-pays but a maximum out-of-pocket of \$950/calendar year.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mandatory enrollment?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of MCOs			
B. Primary care case management (PCCM) program	Yes	No	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)			
E. Other (specify)_____			
F. Other (specify)_____			
G. Other (specify)_____			

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the

mouse, select “insert” and choose “column”.

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ co-payments, or other out-of-pocket expenses paid by the family.)

No, skip to section 3.4

Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/co-payments**		Yes	
Other (specify) _____			

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection? There is a 6-month waiting period under the Phase II plan for children who have had full health insurance within the last 6 months.

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

Employer

Family

- Absent parent
- Private donations/sponsorship
- Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?
The Phase II Program is administered by contract through a private insurance company Blue Cross Blue Shield. The insurance contractor sends the enrolled children an insurance card that indicates whether there is a co-pay or cost-sharing.

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

- Shoebox method (families save records documenting cumulative level of cost sharing)
- Health plan administration (health plans track cumulative level of cost sharing)
- Audit and reconciliation (State performs audit of utilization and cost sharing)
- Other (specify) _____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards						
Brochures/flyers	p	3				
Direct mail by State/enrollment broker/administrative contractor	p	3				
Education sessions	p	4				
Home visits by State/enrollment broker/administrative contractor						
Hotline	p	3.5				
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake	p	3				

Table 3.4.1						
Prime-time TV advertisements						
Public access cable TV						
Public transportation ads						
Radio/newspaper/TV advertisement and PSAs	p	3				
Signs/posters	p	3				
State/broker initiated phone calls						
Other (specify) _____ _____						
Other (specify) _____ _____						

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events	p	4				
Beneficiary's home						
Day care centers	p	4				
Faith communities	p	3.5				
Fast food restaurants	p	3				
Grocery stores						
Homeless shelters	p	2				
Job training centers						
Laundromats						
Libraries						
Local/community health centers	p	4				
Point of service/provider locations	p	3.9				

Table 3.4.2						
Public meetings/health fairs	p	4				
Public housing						
Refugee resettlement programs						
Schools/adult education sites	p	2				
Senior centers						
Social service agency	p	3				
Workplace						
Other (specify) _____ _____						
Other (specify) _____ _____						

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

- 3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Enrollment data are tracked and monitored on a monthly basis by the DOM staff. The State has an approved Section 1915(b) waiver for primary care and case management using primary care physicians (PCP). This program, HealthMACS, is responsible for assessment and evaluation under the PCP waiver and the Medicaid agency intended to use the same staff as well as the Quality Management Division staff to evaluate and assess Phase I CHIP quality of care using the tool, HEDIS. In addition, the Medicaid agency's EPDST staff and reports also monitor and assess compliance with the periodicity requirements for preventive care measures and immunizations.

- 3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?
- 3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) _____	Other (specify) _____
Administration				
Outreach	x	x		
Eligibility determination				
Service delivery	x	x		
Procurement				
Contracting				
Data collection				
Quality assurance				
Other (specify) _____				
Other (specify) _____				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Eligibility determination process:

Waiting period without health insurance (specify) 6 month waiting period for CHIP II

Information on current or previous health insurance gathered on application (specify) _____

Information verified with employer (specify) _____

Records match (specify) _____

Other (specify) _____

Other (specify) _____

Benefit package design:

Benefit limits (specify) _____

Cost-sharing (specify) **Families with income between 150-200% FPL has co-sharing of \$5 for outpatient, non-preventive services and \$15 for emergency room care**

Other (specify) _____

Other (specify) _____

Other policies intended to avoid crowd out (e.g., insurance reform):

Other (specify) _____

Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 4.1.1 CHIP Program Type _____						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children						
Age						
Under 1						
1-5						
6-12						
13-18						

Table 4.1.1 CHIP Program Type

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Countable Income Level*						
At or below 150% FPL						
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL						
1-5						
At or below 150% FPL						
Above 150% FPL						
6-12						
At or below 150% FPL						
Above 150% FPL						

Table 4.1.1 CHIP Program Type

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
13-18						
At or below 150% FPL						
Above 150% FPL						
Type of plan						
Fee-for-service						
Managed care						
PCCM						

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))
N/A

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total						
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact						
Other (specify) _____						
Other (specify) _____						
Don't know						

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll? **A notice is mailed to families 45 days prior to the end of their benefit period requesting updates on income and family status. If returned and deemed eligible according to new information, there is no interruption in coverage. If information update request form is not returned in 10 days, a second notice is sent and contact is attempted by phone.**

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____

FFY 1999 _____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type _____				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures				
Premiums for private health insurance (net of cost-sharing offsets)*				
Fee-for-service expenditures (subtotal)				
Inpatient hospital services				

Table 4.3.1 CHIP Program Type

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Inpatient mental health facility services				
Nursing care services				
Physician and surgical services				
Outpatient hospital services				
Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic services				
Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				

Table 4.3.1 CHIP Program Type _____

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services				

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? Administration associated with implementing the program, systems upgrades and outreach through the media i.e. radio, newspaper, and distribution print media materials.

What role did the 10 percent cap have in program design? N/A

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach						
Administration						
Other						
Federal share						
Outreach						
Administration						
Other _____						

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants

- Private donations (such as United Way, sponsorship)
- Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system withing each program. For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in a Primary Care Case Management program, specify ‘PCCM.’

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits			
PCP/enrollee ratios	X		
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)			
Complaint/grievance/disenrollment reviews			
Case file reviews			
Beneficiary surveys			
Utilization analysis (emergency room use, preventive care use)			
Other (specify) _____			
Other (specify) _____			

Table 4.4.1			
	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Approaches to monitoring access			
Other (specify) _____			

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Requiring submission of raw encounter data by health plans	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requiring submission of aggregate HEDIS data by health plans	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Data not available to identify the CHIP population. Current data measures are being tailored to specify this targeted group from the general Medicaid population.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

The agency staff involved in data collection and reporting will work together to streamline current data collection methods to more effectively identify the children enrolled in the MS Health Benefits Program. More comprehensive data is projected to be available by early June.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in primary care case management, specify ‘PCCM.’

Table 4.5.1			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	planned		
Client satisfaction surveys	planned		
Complaint/grievance/ disenrollment reviews	planned		
Sentinel event reviews			
Plan site visits	planned		
Case file reviews	planned		
Independent peer review			
HEDIS performance measurement			
Other performance measurement (specify)			
Other (specify)			
Other (specify)			
Other (specify)			

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

- 4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Some of the current data measures such as the Codman's tool is not tailored to specific identify the CHIP population.

- 4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

A comprehensive evaluation plan will be developed to include not only monitoring of quality of care, but also care utilization, enrollment/disenrollment rates, associated expenditures and patient satisfaction. Projected date of accomplishment is June,2000.

- 4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

It was discovered in February of this year that the Eligibility Month fields were not being updated when a retro eligibility segment was added. In other words, if a beneficiary became eligible during February (was added to Recipient History) but eligibility was backdated to September of the previous year, Eligibility Month fields would only contain the data for February forward and not the retro period. A CSR has been completed to correct this error and should be completed by mid - to late - May. Data will be resubmitted to HCFA for quarters beginning July 1, 1998. Therefore, the data for these charts can be expected by the end of May at the latest.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

The changes implemented in the eligibility determination and the simplification of the application has been the most effective efforts done to impact the children actually enrolled. State agencies and advocates assisted in the re-design of the application that is currently without complaints.

Provision of one-year continuous eligibility has also had a positive effort on continuous care.

5.1.2 Outreach

The coordinated outreach efforts of the state agencies and advocates in providing statewide trainings and conducting "train the trainers" sessions on the application process for staff and the community has lead to a large number of groups and individuals across the state equipped to help identify and enroll all eligible children,

5.1.3 Benefit Structure

The benefit package for Phases I and II are comprehensive in their coverage in that they both cover in-patient and out-patient health care, preventive services, eye glasses and prescriptions.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

No premiums, deductibles or pre-existing conditions are major power points of the Program.

5.1.5 Delivery System

MS Health Benefits Program is implemented using three state agencies. This coordinated effort has forged stronger working relationship among all parties involved.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

There has been a number of complaints and concerns expressed by a number of families and groups about the six

months waiting period without insurance. Consequently, a bill was passed by the 2000 State Legislature pending signature by the Governor to eliminate the waiting period per HCFA approval.

5.1.7 Evaluation and Monitoring (including data reporting)

There was no complete evaluation plan developed.

5.1.8 Other (specify)

The program had a slow start-up. The Program Coordinator was not hired until February, 2000. Therefore, various components of the evaluation process was not put in place or monitored as needed.

5.2 What plans does your State have for “improving the availability of health insurance and health care for children”? (Section 2108(b)(1)(F))

Plans for improving the availability of health insurance and health care children are as follows:

- seek to provide more out-stationed eligibility workers equipped with la[top computers to complete applications off-site at non-traditional locations and after hours:
- continue to recruit health providers for the target populations especially in rural areas
- provide consumer education of how to effectively use the health care system
- explore the feasibility of presumptive eligibility
- provide needed support to families to insure appointment compliance and completion of the re-determination process.
- conduct consumer focus groups on program implementation and satisfaction.
- conduct local, personalized, customized outreach activities through the use of community-based groups and organizations.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

- **To continue to build on the established collaborative network of state agencies, advocates, the faith-based community and other community-based groups and grants initiatives to assist with the on-going program development and evaluation and outreach efforts.**