

# Early Childhood Access to Health Services: *Final Report*



Mississippi Early Childhood Advisory Council  
Department of Human Services  
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## **Acknowledgements**

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## **EXECUTIVE SUMMARY**

Improving Health Outcomes for very young children is an important issue for Mississippi to tackle. Documented on many levels are the needs identified in Mississippi communities relative to poor health outcomes. The scope of this project examined closely the subject of current state practices coupled with national research to identify actionable solutions for Mississippi's consideration.

Based on the review of the policies and procedures successfully implemented in other states, the following recommendations are made for Mississippi's consideration:

- Change the Medicaid and CHIP eligibility determination process to include the removal of the face-to-face interview requirement.
- Change the Medicaid and CHIP eligibility determination process to include the implementation of "express lane eligibility".
- Change the Medicaid and CHIP eligibility determination process to include the implementation of presumptive eligibility.
- PCG recommends full implementation of Family-Centered Medical Homes, and leveraging enhanced Federal Financial Participation for Medicaid Health Homes under Section 2703 of the Affordable Care Act.
- PCG recommends a Medicaid contract with a dental managed care organization or administrative service organization to improve access to covered dental services.

## **INTRODUCTION**

As the landscape of health care access continues to shift in the country, it has become increasingly important to understand the ability for children and families to access health care. Research shows that infants and young children, especially of low income families, are most at risk of developing health risks if basic screenings and routine check-ups are not administered starting at a young age. Increased awareness of the importance of understanding and improving health care access to young children has led to a national movement to assess health care access to children 0-4 years of age.

The Mississippi State Early Childhood Advisory Council contracted with Public Consulting Group, Inc. to review the state's health resources and practices for children 0-4 years of age and to quantify the need for health services and develop recommendations to make agency practices more efficient.

The project team took a multi-step approach to assessing the state's early childhood health care programs including an identification of indicators of access to health services through research on health insurances status, usual source of care, and mapping the types of health care providers and services in the state. An analysis of statewide programs and services offered through the Department of Health was examined for information regarding program administration, funding, service delivery structure, eligibility criteria, enrollment data, as well as the application process. The project team engaged program administrators and researched publicly available information to assess the accessibility of these programs for young children and families across the state. Barriers to access were identified to better shape the recommendations on options for more efficient and effective service delivery. The cost of the current service delivery system was also evaluated with a breakdown of state and federal funding sources for early childhood health care.

Additionally, the project team conducted best practices research of other state models across the country. Comprehensive state delivery models for early childhood health services including all spectrums of health care services from primary care, dental, to behavioral health were analyzed for best practices.

## **METHODOLOGY**

### **Data requests and Program Interviews**

The project team requested information for review of the State’s administrative policies and procedures for key programs that serve young children. Administrative data were collected to ensure that a comprehensive understanding of the barriers and/or administrative challenges to improved access to health care services for review.

As data provided by the Department and the SECAC, along with reports from relevant agencies, were reviewed, PCG was able to develop data collection and interview tools to record information from stakeholder interviews, independent research, and data collection procedures. PCG created the following standard data collection tools:

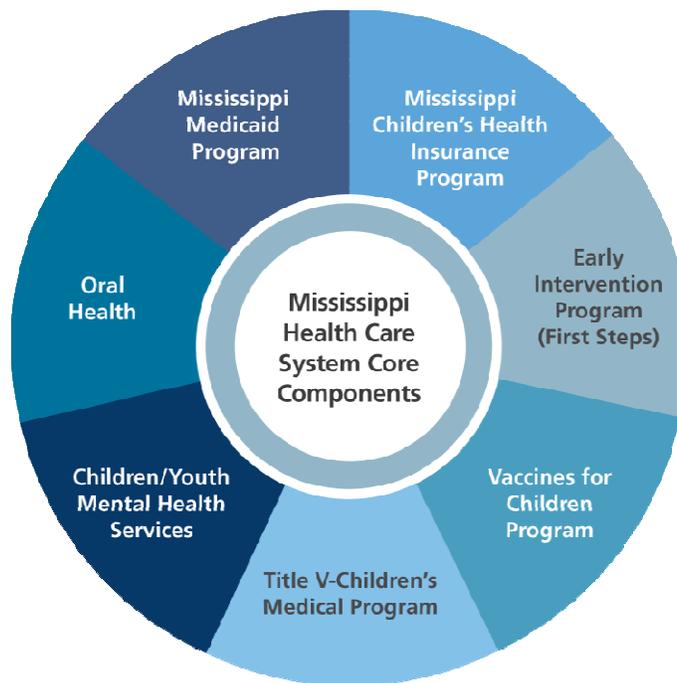
- Agency/Program Data Request: Standard data requests were submitted to the agencies to ensure important documents and materials were gathered for each interview session.
- Standard Interview Questions: PCG developed a standard set of interview questions for each stakeholder interview to ensure all qualitative data collected from key programs were consistent. The team also explored additional topics that may have related to specific issues or barriers to services.

### **Best practice research**

The project team conducted best practices research to gain an understanding of early childhood and health service delivery systems and to identify best practices in improving health and health care for young children. PCG studied publicly available information to identify best practice models from sources such as the BUILD initiative created by the Early Childhood Funders Collaborative, the National Center for Children in Poverty’s Project THRIVE, the Ounce of Prevention Fund, the Commonwealth Fund, and the National Academy for State Health Policy. The project team requested and collected data from identified states and programs to better understand the logic models associated with these programs.

## HEALTH CARE PROGRAMS AND SERVICES

The following section contains program profiles for core components of the health care system in Mississippi. The programs profiled below are not meant to be an exhaustive list but rather key programs relative to health care coverage and access for young children.



### Mississippi Medicaid Program

Medicaid is the nation's major public health coverage program for low-income Americans, financing health and long-term care services for over 55 million people, including families, people with disabilities, and the elderly. The Medicaid program is the third largest source of health insurance in the United States - after employer-based coverage and Medicare. As the largest program in the federal "safety net" of public assistance programs, Medicaid provides essential medical and medically related services to the most vulnerable populations in society. The significance of Medicaid's role in providing health insurance cannot be overstated.

The Medicaid program was enacted in the same legislation that created the Medicare program - the Social Security Amendments of 1965 (P.L. 89-97). Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Medicaid is jointly funded by the Federal government and the state. The Federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP). Mississippi's FMAP matching rate for FY2012 is 74.18%.<sup>1</sup> In other words, Mississippi's Medicaid federally match rate is roughly 3 to 1; every dollar the state contributes to the program is matched with three dollars contributed by the federal government. However, the state must first provide the matching state funds to pull down those federal dollars.

Federal contributions to each state are based on a state's willingness to finance covered medical services and the FMAP matching formula. States must ensure they can fund their share of

<sup>1</sup> FY2012: Federal Register, November 10, 2010 (Vol 75, No. 217), pp 69082-69084, see [[http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2010\\_register&docid=fr10no10-65.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2010_register&docid=fr10no10-65.pdf)]

Medicaid expenditures for the care and services available under their state plan. Recognized sources of funding for the state share of Medicaid payments include:

- Legislative appropriations to the single state agency
- Inter-governmental transfers (IGTs)
- Certified public expenditures (CPEs)
- Permissible taxes and provider donations

Before Centers for Medicare and Medicaid Services (CMS) approves a state plan amendment, they must verify that state funding sources meet statutory and regulatory requirements so they can authorize federal financial participation (FFP) for the covered services.

Medicaid and CHIP provide health coverage to nearly 60 million nationally, including children, pregnant women, parents, seniors and individuals with disabilities. In order to participate in Medicaid, Federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups).

Medicaid is a means-tested entitlement program, which determines eligibility based on the financial means of applicants. To qualify, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of Federal parameters and state definitions. Medicaid is a program that is targeted at individuals with low-income, but not all of the poor are eligible, and not all those covered are poor.

The Federal Medicaid statute defines over 50 distinct population groups as being potentially eligible for States' programs. Some groups are mandatory, meaning that all states that participate in the Medicaid program must cover them; others are optional. Prior to the 1980s, Medicaid eligibility was limited to very low-income families with dependent children, poor elderly and disabled individuals, and the "medically needy." Beginning in the 1980s, additional eligibility pathways were added to the Medicaid statute to allow for the coverage of higher income children and pregnant women as well as other elderly and disabled individuals. The two primary pathways to Medicaid for low-income children are through (1) Section 1931 of Medicaid statute, for those families who would have been eligible for cash welfare payments under former Aid to Families with Dependent Children (AFDC) program rules, and (2) a series of targeted Medicaid expansions for poor pregnant women and children begun in the 1980s.

Between 1986 and 1991, Congress gradually extended Medicaid to new groups of pregnant women and children. Under these provisions, states are required to cover pregnant women and children under age 6 with family incomes below 133 percent of the Federal poverty income guidelines.<sup>2</sup> States are required to cover all children over the age of five and under 19 who are in families with income below 100 percent of the Federal poverty level (FPL). States have the

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<sup>2</sup> 100 percent of FPL is equal to a monthly income of \$1,591 and 133 percent of FPL is equal to \$2,116 for a family of three in 2012.

option to go beyond the above mandatory groups to include pregnant women and infants below one year of age whose family income is over 133 and up to 185 percent of the FPL.

Mississippi Medicaid offers the following programs for children, pregnant women, and low-income parents with children:

- Medical Assistance (COE-085) covers both the parent(s) or needy caretakers and children.
- Expanded Medicaid Program (COE-087) covers children to age 6 under 133% of poverty.
- Infant Survival Program Medical Assistance Program (COE-088) covers pregnant women and children to age one (1) under 185% of poverty.
- Poverty Level Medicaid Program (COE-091) covers children to age 19 under 100% of poverty.

There is no resource test for any of these programs.

States establish and administer their own Medicaid programs, and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain “mandatory benefits,” and can choose to provide other “optional benefits” including prescription drugs. States receive federal matching funds to provide these benefits.

**Table 1. Federally Mandated Medicaid Services**

<b>Federally Mandated Services</b>
Nurse Midwife Services
Nurse Practitioner Services (pediatric and family)
Family Planning Services
Federally Qualified Health Center Services
Nursing Facility Services
Home Health Services
Inpatient Hospital Service
Outpatient Hospital Services
Physician Services
Laboratory and X-ray Services
Rural Health Clinic Services
Non-emergency Transportation EPSDT Services
<b>Optional Services Covered</b>
Ambulatory Surgical Center Services
Inpatient Psychiatric Services
Chiropractic Services
Christian Science Sanatoria Services

Mental Health Services
Pediatric Skilled Nursing Services
Dental Services
Disease Management Services
Durable Medical Equipment
Perinatal Risk Management Services
Podiatrist Services
Prescription Drugs

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a mandatory service under Medicaid that provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). The EPSDT Program was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. These services were expanded in section 1905 (r) (5) of the Social Security Act (the Act) to require that any medically necessary health care service listed in section 1905 (a) of the Act be provided to an EPSDT beneficiary even if the service is not available under the State Plan.

In 2007, the Mississippi Division of Medicaid began marketing its EPSDT program as the “Mississippi Cool Kids” program. The Mississippi Cool Kids program combines screening services and diagnostic and treatment services to provide preventive and comprehensive health services to Medicaid eligible beneficiaries from birth to age twenty-one (21). Diagnostic and treatment services which are medically necessary to treat a condition identified during a screening must be covered by the Medicaid program to the extent that federal Medicaid law allows such coverage. Expanded EPSDT services include any necessary Medicaid reimbursable health care to correct or ameliorate illnesses and conditions found on screening. EPSDT (Expanded) services are any medical services for children from birth to age 21 (eligible through the last day of their birthday month only) that fall outside of the regular services covered by Medicaid and are deemed medically necessary. Services not covered, or exceeding the limits set forth in the Mississippi State Plan, must be prior authorized by Division of Medicaid (DOM) to ensure medical necessity.

In order to administer the EPSDT program, the DOM and potential EPSDT providers, including but not limited to, the State Department of Health, other public and private agencies, private physicians, rural health clinics, comprehensive health clinics, and similar agencies which provide various components of EPSDT services, must sign an EPSDT specific provider agreement. Diagnostic and treatment services are primarily provided by referral to other providers. A primary care referral list of EPSDT providers in the county must include pediatricians, family and general practice physicians, internal medicine physicians, vision and hearing providers and dentists.

States can establish their own Medicaid provider payment rates within federal requirements. States generally pay for services through fee-for-service or managed care arrangements. Most Mississippi Medicaid services are provided under fee-for-service

arrangements where the state pays providers directly for services rendered. States may develop their payment rates based on:

- The costs of providing the service;
- A review of what commercial payers pay in the private market; and/or
- A percentage of what Medicare pays for equivalent services.

Under managed care arrangements, states contract with organizations, which are generally paid on a monthly capitation payment rate, to deliver care through networks and pay providers. Effective January 1, 2011, DOM established the Mississippi Coordinated Access Network (Mississippi CAN), a coordinated care program for Mississippi Medicaid beneficiaries. DOM has contracted with two Coordinated Care Organizations (CCOs), Magnolia Health Plan and United Healthcare, who are responsible for providing services to individuals enrolled in Mississippi CAN. Individuals eligible for Medicaid in the following coverage groups may elect to participate:

- SSI;
- Disabled Child Living at Home;
- Working Disabled;
- Department of Human Services Foster Care Children; or
- Breast/Cervical Cancer Group.

With the passage of HB 421 by 2012 regular session of the Mississippi Legislature, DOM is anticipating phasing in an expansion of Mississippi CAN beginning in January 2013. Participation in Mississippi CAN will be mandatory under the planned expansion. In addition to the eligibility groups listed above, Pregnant Women eligible for Medicaid benefits will be included.

A person interested in applying for Medicaid can call the Medicaid Regional Office that serves the county where the person lives. Applications available at the Medicaid Regional Office serving specific communities or at other locations which serve children's needs, can be obtained on <http://www.medicaid.ms.gov/ApplyForMedicaid.aspx>, and are also mailed upon request. When an application is received by the regional Medicaid office, a Medicaid Specialist is assigned to process the application, which includes the requirement for an in-person interview. Depending on the eligibility group, Medicaid is allowed between 45 and 90 days to process the application.

### **Mississippi Children's Health Insurance Program**

Section 4901 of the Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) established Title XXI of the Social Security Act and created the Children's Health Insurance Program (CHIP) additional coverage group for low-income children. Section 4911 of BBA 97 establishes a Medicaid coverage group that is parallel to the group of children eligible for health coverage under another provision of BBA 97, the State Children's Health Insurance Program (Section 4901). The two provisions allowed states to choose, after the passage of BBA 97, to either

extend Medicaid for targeted low-income children, to create a new SCHIP program for those children, or coordinate both programs to cover the target population.

Targeted low-income children are those who are not otherwise eligible for Medicaid, are not covered under a group health plan or other insurance, and are living with families with income that is either: (1) above the State's Medicaid financial eligibility standard in effect in June 1997 but less than 200 percent of the FPL; or (2) in states with Medicaid income levels for children already at or above 200 percent of the poverty level as of June 1997, within 50 percentage points over this income standard. States either can establish a specific coverage group for targeted low-income children or they can build upon other existing Medicaid coverage groups for children.

MISS. CODE ANN. Section 41-86-1 et seq. (1972) set out minimum requirements for the state's CHIP and authorized a CHIP Commission to structure a program consistent with minimum standards set forth in federal and state laws. Following the guidelines promulgated by state law, the CHIP Commission recommended that Mississippi's Children's Health Insurance Program operate as a separate, fully insured program under the direction of the State and School Employees' Health Insurance Management Board. The Division of Medicaid also has CHIP responsibilities and the division's officials are ultimately held responsible by the Federal Centers for Medicare and Medicaid Services for program administration and oversight.

The CHIP is a joint federal/state program funded primarily through a block grant from the federal government that is based on the number of children in low-income families, the number of those children who are uninsured, and the state cost factor. The federal government provides the majority of the funding for the program. In CHIP, expenditures are generally reimbursed at the enhanced FMAP (E-FMAP), which was 81.93% % for Federal Fiscal Year 2012.

CHIP provides insurance coverage for uninsured children up to age 19 whose family income does not exceed 200% of FPL. A child must be determined ineligible for Medicaid before eligibility for CHIP can be considered. Children with current health insurance coverage at the time of application are not eligible for CHIP.

Like Medicaid, CHIP in Mississippi covers a wide range of services. Services include: health screenings (including vision 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 medications; eyeglasses and hearing aids; dental care; and mental health services. Mississippi operates its separate CHIP to provide "benchmark equivalent plus" coverage. This means that Mississippi's CHIP provides all of the benefits provided by the benchmark plan (i. e., the State and School Employees' Life and Health Plan), as well as additional benefits (e. g., dental and vision coverage).

The current CHIP insurer, Blue Cross Blue Shield of Mississippi (BCBSMS), was selected through a competitive bidding process. The current agreement allows the insurer to operate similar to a third-party administrator. There are no premiums or deductibles, although there may be a small co-payment for some services for higher-income families on CHIP.

Applications for Mississippi CHIP are available by mail and at many locations that serve children's needs including Medicaid Regional Offices, local health departments, community health centers, rural health clinics, Head Start centers, public schools, and some hospitals and private clinics. Applications for CHIP, similar to Medicaid, require an in-person interview by the parent or caretaker. It's possible that one child in a family may qualify for Medicaid while another may qualify for CHIP. Eligibility is based on household income, the age of each child and the insured status of each child. The DOM Regional Office will determine the appropriate program for each child. Eligibility is continuous for one year for children under age 19.

### **Early Intervention Program (First Steps)**

First Steps is a Mississippi statewide early intervention program which provides services to children age birth to three that have developmental, physical, or social/adaptive problems. Early Intervention Services are designed to meet the developmental needs of each child eligible under Part C and also the needs of his/her family related to the child's development. For CY 2010, there were 4,141 children referred to the Early Intervention Program. Families of these infants and children receive a comprehensive evaluation and have access to all necessary early intervention services if eligible.

The eligibility requirement for infants and toddlers with developmental delays or disabilities must be one of the following:

- Experiencing a 25% developmental delay in:
  - Cognitive development;
  - Physical development;
  - Communication development;
  - Social/emotional development;
  - Adaptive Skills.
- A diagnosed physical or mental condition that has a high probability of resulting in developmental delay.
- A diagnosed medical condition that has a high probability of causing substantial developmental delays if early intervention services are not provided.

Once a child is found eligible a team led by a service coordinator works with the family to develop an Individualized Family Service Plan (IFSP) to provide appropriate services to the child and family using professional resources within the community. These services might include: assistive technology, family education, developmental therapy, occupational therapy, physical therapy, speech therapy, or psychological services. In CY 2010, the number of children served according to an IFSP was 4,122. These services are provided to families at no cost. Medicaid pays for the majority of early intervention services, with private insurance paying for others, and federal grant funds are used to pay for the remainder of the services for which there is no other funding source. First Steps is also responsible for administering the Early Hearing Detection and Intervention Program, which coordinates the early identification and appropriate referral to services for infants and toddlers with identified hearing impairments.

The primary goal of First Steps is to assure that all eligible infants and toddlers with developmental disabilities receive the necessary and appropriate early intervention services throughout the state.

### **Vaccines for Children Program**

Mississippi Law requires immunizations against childhood diseases in order for children to enter school, Head Start, or day care. There are also specific vaccinations required for students entering high school and college. The Division of Immunization within the Mississippi State Department of Health provides these necessary immunizations at a low cost to ultimately eliminate the incidence of vaccine preventable diseases in children and adolescents. These childhood vaccinations include:

- Measles, Mumps and Rubella;
- Chicken Pox;
- Diphtheria, Tetanus and Pertussis (Whooping Cough);
- Hepatitis A and B;
- Hib (Haemophilus influenza Type b);
- Polio;
- Influenza; and
- Childhood Pneumonia.

These services can be administered through the Vaccines for Children (VFC) Program which is provided by the Division of Immunization.

The VFC was established by President Clinton's Childhood Immunization Initiative and passage of the Omnibus Budget Reconciliation Act in 1994. It is a federally- funded and state-operated program. VFC is jointly administered by the Division of Immunization at the Mississippi State Department of Health and the Mississippi Division of Medicaid.

VFC allows children, zero through 18 years of age to receive free vaccines. The eligibility requirement for children in this program must be one of the following:

- Must receive Medicaid;
- be Native American or Alaskan Natives; or
- has health insurance but immunizations are not covered.

The creation of a medical home for children is promoted by VFC by enticing provider participation. The program also raises awareness of childhood immunizations and can reduce the number of referrals to public health clinics. If health care providers are willing to enroll in the program and agree to follow the Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule they may receive the VFC vaccine and administer the vaccine at no charge. The provider must agree to administer the vaccine at no cost, although the provider is allowed to charge a \$10 administration fee per vaccine if the parent is able to pay. Clients can also be billed for a separate office visit by providers, which are reimbursed by

Medicaid in addition to the administration fee. There are 250 private health care providers currently enrolled in the Mississippi VFC Program.

### **Title V-Children's Medical Program**

Enacted in 1935 as a part of the Social Security Act, the Title V Maternal and Child Health Program is the Nation's oldest Federal-State partnership. For over 75 years, the Federal Title V Maternal and Child Health program has provided a foundation for ensuring the health of the Nation's mothers, women, children and youth, including children and youth with special health care needs, and their families. Title V converted to a Block Grant Program in 1981.

Specifically, the Title V Maternal and Child Health program seeks to:

1. Assure access to quality care, especially for those with low-incomes or limited availability of care;
2. Reduce infant mortality;
3. Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women);
4. Increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
5. Provide and ensure access to preventive and child care services as well as rehabilitative services for certain children;
6. Implement family-centered, community-based, systems of coordinated care for children with special healthcare needs; and
7. Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

The Maternal and Child Health Services Block Grant includes State Formula Block Grants, Special Projects of Regional and National Significance (SPRANS), and Community Integrated Service Systems (CISS) projects. Section 502 of the Social Security Act states that of the amounts appropriated, up to \$600,000,000, 85% is for allocation to the states, and 15 % is for SPRANS activities. Any amount appropriated in excess of \$600,000,000 is distributed as follows: 12.75% is for CISS activities; of the remaining amount, 85% is for allocation to the states, and 15% is to support SPRANS activities. Individual state allocations are determined by a formula which takes into consideration the proportion of the number of low-income children in a state compared to the total number of low-income children in the United States.

MSDH is the state agency responsible for administering the Title V MCH Block Grant. These funds are allocated in the central office to the Offices of Women's Health and Child and Adolescent Health. CMP is located in the Office of Child and Adolescent Health. All are located organizationally within Health Services (HS). Women's Health and Child and Adolescent Health provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs.

The Mississippi State Department of Health applies for and receives a formula grant each year. In addition to the submission of a yearly application and annual report, State Title V programs are also required to conduct a state-wide, comprehensive Needs Assessment every five years. States and jurisdictions use their Title V funds to design and implement a wide range of Maternal and Child Health and Children with Special Health Care Need activities that address National and state needs. Unique in its design and scope, the Maternal and Child Health Block Grant to States program:

1. Focuses exclusively on the entire maternal and child health population;
2. Encompasses infrastructure, population-based, and direct services for the maternal and child health population;
3. Requires a unique partnership arrangement between Federal, state and local entities;
4. Requires each state to work collaboratively with other organizations to conduct a state-wide, comprehensive Needs Assessment every 5 years;
5. Based on the findings of the Needs Assessment, requires each state to identify state priorities to comprehensively address the needs of the MCH population and guide the use of the Maternal and Child Health Block Grant funds; and
6. May serve as the payer of last resort for direct services for the maternal and child health population that are not covered by any other program.

Mississippi's most recent Needs Assessment resulted in the following new state priorities:

1. Low birth weight and preterm birth, preconception care
2. Teen pregnancy and teen birth rate
3. Nutrition and physical activity
4. Adolescent alcohol and drug use
5. Violence (e.g., sexual assault, bullying)
6. Sexually transmitted disease
7. Adult immunizations

In addition to the new state priorities, Mississippi's Needs Assessment also resulted in the following new state Performance Measures:

1. Percent of infants born with birth weight less than 1,500 grams
2. Rate of pregnancy among adolescents aged 15-19 years
3. Percent of students who met recommended levels of physical activity
4. Percent of students who reported current cigarette use, current smokeless tobacco use, or current cigar use
5. Percent of students who reported current alcohol, marijuana or cocaine use
6. Percent of students who did not go to school on at least 1 day during the prior 30 days before because they felt they would be unsafe at school or on their way to or from school
7. Rate of Chlamydia, gonorrhea, and syphilis cases per 100,000 women aged 13-44 years
8. Percent of women aged 13-44 years who received an influenza vaccination within the last year
9. Percent of women having a live birth who had a previous preterm or small-for-gestational age infant

The Mississippi Children's Medical Program provides medical and surgical care to children with chronic or disabling conditions. The service is available to state residents up to 20 years of age, born with a disabling condition, or developed a disability or chronic illness. The Children's Medical program can organize care for a child's condition, provide equipment and drugs, and arrange for physical, occupational and other therapies.

**Table 2. Title V-Children’s Medical Program Eligibility, Services, & Application Requirements**

<i><b>Eligibility</b></i>	
Mississippi residents from birth to age 20 are eligible. Patients must qualify, based on family income, family size, and estimated cost of treatment. The Children’s Medical program covers the following conditions and more:	
<ul style="list-style-type: none"> <li>➤ Spina bifida</li> <li>➤ Cerebral palsy</li> <li>➤ Cleft palate</li> <li>➤ Seizure disorders</li> <li>➤ Cystic fibrosis, sickle cell anemia, and hemophilia (through special programs)</li> </ul>	<ul style="list-style-type: none"> <li>➤ Hydrocephalus</li> <li>➤ Orthopedic problems (other than from accidents)</li> <li>➤ Congenital heart problems requiring surgery</li> <li>➤ Intestinal or urinary defects requiring surgery</li> </ul>
<i><b>Services</b></i>	
Pediatric specialty care (outpatient and inpatient) include:	Services are <b>not</b> covered for:
<ul style="list-style-type: none"> <li>➤ Braces and other durable medical equipment</li> <li>➤ Some drugs, such as seizure medications, through the State Public Health Pharmacy</li> <li>➤ Dental corrections and speech therapy for some conditions</li> <li>➤ Genetic screening referral and follow-up</li> <li>➤ Pediatric social workers for evaluation and referral to other community resources</li> <li>➤ Nutrition services</li> </ul>	<ul style="list-style-type: none"> <li>➤ Illnesses such as colds and flu</li> <li>➤ Child care for children who are not sick</li> <li>➤ Injuries</li> <li>➤ Non-surgical care related to premature birth</li> <li>➤ Allergies</li> <li>➤ Malignancies (except when reconstructive surgery is needed)</li> <li>➤ Mental, behavioral and emotional disorders</li> </ul>
<i>Except for emergencies, services must be pre-approved through the Children's Medical</i>	

<i>Program</i>	
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<b><i>Application Requirements</i></b>
Families apply at local health departments. Applicants must provide the documents below.
<ul style="list-style-type: none"> <li>➤ A statement with specific diagnosis, requested services, and referral from a physician, if available.</li> <li>➤ Copies of pertinent medical reports about their child's problem</li> <li>➤ Complete and accurate financial information</li> <li>➤ <b>Names, relations and ages of all household members</b></li> <li>➤ Private insurance or Medicaid card, if applicable</li> <li>➤ Signature of parent or legal guardian</li> </ul>

The program currently operates a limited number of satellite clinics throughout the state to provide specialized care in the local community in addition to a central multi-discipline clinic in Jackson at Blake Clinic for Children. Services include hospitalization, physicians' services, appliances, and medications. Funding for this program comes from federal Maternal and Child Health funds and other state and federal sources.

***Critical Note***

*The Children's Medical Program (CMP), Mississippi's Children with Special Health Care Needs Program, is in the process of reviewing and restructuring their internal policy and procedures starting with the revision of their interoffice policy and procedural manual. It is CMP's intent to maximize direct services and care coordination efforts to meet the greatest need. Through this process, CMP has restructured some of the services they currently cover for their specialty group of patients over the age of twenty-one, which includes sickle cell, cystic fibrosis, and hemophilia patients. The discontinued coverage will impact office visits, emergency room visits and hospitalization beginning January 1, 2012. The impact of this change has not been determined. Anticipating the impact of this change in services, CMP provided approximately one year advance notice to all patients who may be affected. In the interim, patients have been urged to seek other sources of health care coverage through Mississippi Medicaid or private insurance. CMP has urged patients who may benefit from employer group health or their parents' health care plans to remain cognizant of open enrollment periods at which time they may be added. CMP's social service staff offers assistance by referring this patient population to other resources as needed. CMP has implemented a check and balance process in handling authorization requests for payment from CMP providers. Currently, the authorization process*

*entails a systematic approach to ensure that the greatest use of CMP funds is utilized and payment is rendered on a payer-of-last-resort basis.*

## **Children/Youth Mental Health Services**

The Mississippi Department of Mental Health (DMH), Division of Children and Youth Services, has the responsibility of determining the mental health needs of children/youth across the state and administering the programs to address those needs. DMH offers a wide array of services through contracting with fifteen (15) comprehensive community's mental health centers (CMHCs) and twenty-two (22) other non-profit agencies. DMH administers state and federal funds for direct community mental health services for youths, including CMHCs, public mental health providers, and private non-profit service agencies. Additionally, state match dollars for Medicaid reimbursement for mental health services are allocated annually by the State Legislature to DMH (primarily covers assessments, prevention, outpatient services, day treatment, and peer specialist).

DMH generally serves all children and youth in need of mental health services. DMH has collaborated and coordinated with other agencies to identify seriously emotionally handicapped children in Mississippi. Mississippi uses the Diagnostic and Statistical Manual of Mental Disorders (DSM) to define children who meet the criteria of a mental disorder that results in functional impairment in basic living skills, instrumental living skills, and/or social skills. On an annual basis, nearly 35,000 children and youth in Mississippi have been identified with severe/persistent mental health needs that impact their lives.

The range of mental health services provided to children and youth with serious emotional disorders is community-based, with advocacy and support networks. Most services are included within the following major components:

### **1. Prevention and Early Identification Services**

#### Prevention Programs

These programs provide services to vulnerable at-risk groups prior to the development of mental health problems. Children especially vulnerable include children in one-parent families, children of mentally ill parents, children of alcoholic parents, children of teen parents, children in poor families, children of unemployed parents, children with an incarcerated parent, children who have been abused or neglected and children with physical and/or intellectual handicaps.

#### Early Intervention Programs

These programs are designed most often to include collaboration among service programs and agencies. The key factor to early intervention is identification of the person, program, agency, or service that serves as the first contact relative to problems or suspected problems with the child or youth. Early intervention is not defined as only those services or programs designated for young children. It includes programs for all ages of children and adolescents and implies intervention is implemented as early or as soon as problems are suspected and/or identified. Early intervention programs also are

aimed particularly at the vulnerable at-risk groups of children and adolescents. Many programs would have both prevention and early intervention components targeted at the same at-risk populations.

## **2. Community-Based Nonresidential Treatment Services**

### Diagnostic and Evaluation Services

Diagnostic and Evaluation Services encompass appropriate formal early diagnostic and evaluation services, i.e., psychiatric and psychological evaluations, and social histories that must be performed to develop the most appropriate service plan for each child. In the process of diagnosing severely emotionally disturbed children, a variety of methods are used ranging from observation to behavior checklists and projective tests to structured interview with families and clients.

The role of assessment in the system for emotionally disturbed children and youth is particularly important due to the complexity of their problems and the failure of their problems to fit into established diagnostic categories. The usefulness of assessment procedures with emotionally disturbed children is dependent upon the general clinical knowledge and skills of the professionals involved as well as the knowledge of the potential value of various services within the system of care.

### Outpatient Services

Outpatient Services include individual, group, and family therapy and parent education classes, as well as home-based services which may or may not be crisis oriented. This is the least intensive and most typically used intervention in the mental health field. It is provided in such diverse settings as community mental health centers, child guidance clinics, schools, outpatient psychiatry departments of hospitals, local health departments, and other non-profit child service agencies.

Home-Based Services are intensive and include short-term therapy which is provided in the home on a 24-hour basis to families with an entire family orientation rather than a therapeutic orientation of a primary client. These services are aimed at maintaining the child/children in the home and school environments during a crisis situation for the family.

### Therapeutic Support Services

Therapeutic Support Services include staff training, transportation, and volunteer services provided by or through the mental health provider. These differ from system wide support services in that they are identified by the mental health provider as critical to accessing or implementation of mental health services.

### Day Treatment

Day treatment is the most intensive of the non-residential services that usually continues over a longer period of time. Children typically remain in day treatment for at least one school year although there are programs designed for briefer lengths of participation. The

most common day treatment model is a service that provides an integrated set of intensive therapeutic services with family intervention and support services involving a child/youth for at least two hours a day, twice a week up to five hours a day, five times each week.

These programs frequently involve collaboration between mental health and education agencies. The treatment may be provided in a variety of settings, such as regular school settings, special school settings, or in community mental health centers, hospitals, or elsewhere in the community. Other models are available utilizing different formats such as after-school or evening programs.

The specific features of day treatment programs vary from one program to another, but typically include the following:

- a) Structured, prescriptive individualized and small group approaches;
- b) Counseling which may include individual and group counseling approaches;
- c) Family services including family counseling, parent training, brief individual counseling with parents and case management;
- d) Vocational training, particularly for adolescents;
- e) Crisis intervention not only to assist students in difficult situations but to help them improve their problem-solving skills;
- f) Skills-building with an emphasis on interpersonal and problem-solving skills and practical skills of everyday life;
- g) Behavior modification with a focus on promoting success through the use of positive reinforcement procedures; and,
- h) Recreational therapy, art therapy and music therapy to further aid in the social and emotional development of these children/youth.

#### FASD Screening, Diagnosis and Intervention

The MDMH Division of Children and Youth Services implements the Mississippi Fetal Alcohol Spectrum Disorders (FASD) initiative in order *to improve the functioning and quality of life of children and youth and their families by diagnosing those with an FASD and providing interventions based on the diagnosis*. The initiative targets children who are referred to the Community Mental Health Centers (CMHC) for services or who are referred to one of the local Making a Plan (MAP) Teams for services.

Children's service staff at each of the 15 community mental health centers in the state has received intensive FASD-specific training to enable them to screen children for the risk of FASD and then make referrals for diagnostic evaluations through the University of Mississippi Medical Center (UMC) Child Development Clinic to determine if the child does indeed have an FASD. Following the diagnostic evaluation, the CMHC staff must modify the child's service plans to include the treatment recommendations and behavioral interventions provided by the UMC clinicians. The community mental health centers collect FASD-specific data and submit this data to the FASD project staff at MDMH in the form of monthly reports or other special reports.

### **3. Community-Based Residential Treatment Services**

#### Respite Services

Respite service is planned temporary care for a period of time ranging from a few hours within a 24-hour period to an overnight or weekend stay up to as much as 90 days depending on program guidelines. Respite may take the form of in-home or out-of-home services with trained respite parents or counselors and is designed to provide a planned break for the parents from the caretaking role with the child. Respite programs may be designed as a community-based residential or non-residential service. Respite may also be provided on an inpatient basis in a local or state hospital.

#### Emergency Short-Term Placement

This type of crisis emergency service is the type of intensive and immediate intervention that would be provided at a time of crisis to the child and family. The emergency placement would occur outside the home and could include crisis counseling as well as the capacity for emergency evaluations if they are needed. Services would be closely coordinated with emergency residential services in cases where it is determined that the child or youth is at such risk that 24-hour care and supervision are needed beyond the emergency short-term placement of up to 72 hours.

#### Therapeutic Foster Homes

These homes provide residential mental health services to emotionally disturbed children or adolescents in a family setting, utilizing specially trained foster parents. Therapeutic foster care essentially involves the following features:

- a) Placement of a child with foster parents who have been recruited specifically to work with an emotionally disturbed child;
- b) Provision of special training to the foster parents to assist them in working with an emotionally disturbed child;
- c) Placement of only one child in each special foster home (with occasional exceptions);
- d) A low staff-to-client ratio, thereby allowing clinical staff to work very closely with each child, with the foster parents, and with biological parents if they are available;
- e) Creation of a support system among the foster parents; and,
- f) Payment of a special stipend to the foster parents for working with the emotionally disturbed child, and for participating in the training activities of the program.

#### Therapeutic Group Homes

This type of treatment provides residential mental health services to children and adolescents who are capable of functioning satisfactorily in a group home setting. The purpose of the therapeutic group care is to provide a therapeutic environment using specially trained "house parent" staff as key therapists. Service is provided in homes

which typically serve from five to ten youth with an array of therapeutic interventions utilizing program staff, as well as other mental health professionals.

For therapeutic group care programs, the primary mission is treatment, and the primary target population is children/adolescents with serious emotional disorders. A therapeutic group home, generally, is a single home located in the community. In Mississippi, the models for treatment include the TF Model or Teaching Family Model and the TR (Therapeutic Recreation) Model or the Transition from Hospital to Community Model.

The model for therapeutic group home services recognizes the importance of developing specific services to help adolescents make the transition to independent living. Services of other child-serving agencies are sometimes utilized to reach this goal.

#### Residential Treatment for the Substance Abusing Adolescent

This type of treatment provides residential services to adolescents who are capable of functioning satisfactorily in this environment. The purpose of the treatment is to provide a therapeutic environment in a program to treat chemically dependent adolescents. It is provided in facilities which typically serve from five to ten adolescents and provides an array of therapeutic interventions and treatment.

For therapeutic residential programs for substance abusing adolescents, the primary mission is treatment and the primary target population is chemically dependent adolescents. These programs, like the therapeutic group home for emotionally disturbed adolescents, usually are single homes located in the general community. The model includes psychological, educational, social and specific substance abuse interventions appropriate to adolescents.

#### Residential Treatment Center

This type of program provides residential treatment for the severely emotionally disturbed child or adolescent. A Residential Treatment Center provides 24-hour per day treatment in a setting with multiple living units able to serve a wider variety of clients. Each living unit, typically, will house 8 to 16 children or adolescents offering specialized services, if necessary, by age or severity of disorders. A Residential Treatment Center may have a strong medical component or a strong psychosocial approach. Other treatment components include individual, group, and family therapy; behavior modification; special education and recreational therapy.

#### Inpatient Psychiatric Hospital Care (Specialized Psychiatric Hospital)

This service may be designed to provide either acute, short-term (90 days or less) or longer-term intensive psychiatric services to more severely disturbed children or adolescents in a hospital-based residential setting. A single hospital unit may provide either or both types of services. This type of service, typically, is the most expensive; the most closely supervised with the most intensive treatment, and has the highest percentage of medical staff. Inpatient psychiatric hospital care is reserved for extreme

situations which include youngsters who are demonstrating serious acute disorders or particularly perplexing and difficult ongoing problems or are an immediate danger to themselves or others.

#### Inpatient Alcohol and Drug Treatment (Specialized Substance Abuse Hospital Programs)

There are numerous similarities between inpatient and community residential treatment for substance abusing adolescents. These include the following: (a) both offer treatment for drug and alcohol abuse; (b) both are 24-hour, seven day a week programs; and (c) both provide a structured daily schedule that typically includes individual counseling, group therapy, recreational activities, educational activities, and opportunities for family counseling. One of the primary differences between inpatient treatment and community residential treatment for substance abusing adolescents is that inpatient treatment provides medical staff as active, permanent members of the treatment team. The second major difference between the two program types is in the length of stay which is typically shorter for inpatient. The average length of stay for inpatient treatment ranges from 30 to 45 days.

#### Transitional Services

These services are designed to help adolescents make the transition to independent living and preparation for paid employment. Such services can be provided in a foster home, group living, residential treatment center, supervised apartment, or day treatment setting. The emphasis is to provide individuals with the information and skills to manage financial, medical, housing, transportation, special/recreational, and other daily living needs. Close involvement is required with vocational education components of school systems, vocational rehabilitation agencies, and job training programs.

### **4. Crisis Intervention and Emergency Response**

#### Crisis Intervention/Emergency Response

This type of emergency response can range from immediate brief response by appropriate mobile mental health response personnel up to several hours. Triage is typical in this type of immediate response to crisis (es). Emergencies can occur at a variety of locations in the community (e.g., home, school, playground, etc.) and emergency response must have the capability to respond appropriately in a timely and professionally adequate manner. There are Crisis Intervention Centers throughout the state that provides these services, as well as a toll-free help line (1-877-210-8513).

### **5. Family Support and Education**

#### Family Education and Support Services

Children with mental health needs often have educational, economic, health, vocational and other support needs. For example, a child with severe emotional disorders may need special education, financial assistance, and structured living situations. Thus, a wide variety of services must support the delivery of mental health services. Family education programs, such as the Developing Families as Allies program, are an important part of this array. They are often available through community mental health centers.

## 6. **Advocacy and Protection**

### Advocacy and Protection and Support Services

The presence of a serious emotional disorder can also severely limit access for a child or adolescent to available support services, e.g., vocational rehabilitation, medical care, dental care, health services, nutritional assistance, and transportation. Therefore, advocacy and support are provided through agencies such as the Mississippi Families as Allies Parent network, the Mississippi Chapter of the National Alliance on Mental Illness, and the Mississippi Protection and Advocacy Center.

## 7. **Other Support Services**

### Case Management

This is a wrap-around component of the system of care that provides service to children and adolescents in any of the treatment settings or prevention/early intervention programs. It involves brokering services for individual youngsters, advocacy on their behalf, ensuring that an adequate treatment plan is developed and is being implemented, reviewing client progress, and coordinating services. Case Management involves aggressive outreach to the child and family in working with them and with numerous community agencies.

DMH is taking on the tremendous task of serving the early childhood population in need of mental health services. Based on discussions with DMH stakeholders, the issues that are hindering the Department from fully maximizing the current resources are included below:

- Lack of collaboration within other state agencies working with early childhood populations (such as the Department of Education, etc.);
- Gaps of service coordination between CMHCs and Childcare Centers;
- Prior authorization requirements hindering children/families from obtaining the healthcare coverage;
- Lack of sufficient training for the mental health workforce; and
- Underutilization of EPSDT screenings for young children.

## **Oral Health**

### Department of Health, Division of Dental Services

The Mississippi's Division of Dental Services resides in the state's Department of Health. The division oversees statewide programs aimed at prevention and control of oral diseases through assessment, policy and program development, and assurance. The division's programs address children, adults, and families in communities through public health clinics, schools, and approved dental health providers.

The programs and services provided by the Division of Dental Services include:

- **Fluoride Programs**- the fluoride water treatment program is a cost-effective way to prevent tooth decay. When added to community water systems that may require it, fluoride treatment can provide early, long-lasting prevention for children against oral and dental disease. The MS fluoride program is a key example of collaboration in the state's

oral health community; funding for the program comes from federal and state funds, as well as local foundations.

- **Dental Sealant Program-** *Mississippi Seals* provides preventive dental services in schools throughout the state. Dental screenings, dental sealants, and fluoride varnish applications are provided on-site in schools by dental professionals in the community.
- **Regional Oral Health Consultants (ROHCs)** - The MSDH Regional Oral Health Consultants (ROHCs) strive to improve the oral health of all Mississippians by assisting county health departments to deliver age-appropriate oral health anticipatory guidance and preventive oral health services in each public health district. ROHCs are Registered Dental Hygienists that promote information sharing between health professionals and community stakeholders to educate the public about the importance of good oral health and to reduce the burden of oral disease. Currently, the state has eight ROHCs, one manages school-based dental sealant programs, while the remaining provides education and outreach services in public health districts across the state.

Make a Child Smile-Head Start- This preventive dental program provides for dental screenings and protective fluoride varnish for children enrolled in Head Start. The services include a visual oral health screening and an application of fluoride varnish. With parent's permission, a dental hygienist evaluates children for noticeable dental problems and also applies a thin coating of fluoride varnish on the child's teeth to prevent dental decay. Fluoride varnish is a protective coating of fluoride applied to teeth to prevent dental decay. It is safe and recommended for use at least two times per year. Parents of participants receive results of their dental assessment.

The Mississippi Head Start program periodically conducts a dental survey to assess the oral health status of pre-school aged children. The survey informs efforts to create and implement oral health education programs to reduce the proportion of children with dental caries (tooth decay or cavities). The most recent state Head Start Dental Survey completed in 2007-2008, assessed 2,128 children enrolled in 22 randomly selected centers (at the time there were 220 Head Start centers with an enrollment of 23,743 children). The study indicated that despite the state's Head Start program efforts, young children are not receiving proper oral health services. The study found that dental decay is a major problem for MS Head Start children, ages 3-5 with:

- 56 percent of children having cavities and/or fillings (caries experience)
- 41 percent having untreated cavities (dental decay)
- 7 percent of children needing urgent treatment due to pain or discomfort, swollen tissue or inability to eat

## **IDENTIFIED BARRIERS TO ACCESS**

Throughout our project scope, the PCG team identified the barriers which hinder young children from accessing health services. Based on our interviews with various stakeholders, research on the provision of health services in other states, and analysis of current service offerings, we were able to identify local-level issues affecting the impact of community services, as well as larger issues that have a statewide impact. For a detailed state to state comparison of Mississippi and states with similar demographics and health care indicators, please see Appendix A.

In this section, we present the identified barriers that impact children’s ability to fully access health services in Mississippi. Listed below are the high-level barriers, which include supporting feedback to clarify the barriers’ impact:

- 1) Health Insurance Coverage
- 2) Access to Primary Care
- 3) Access to Mental Health Care
- 4) Access to Dental Care
- 5) Other Barriers to Access

### Health Insurance Coverage

Many of the stakeholders in this study noted that there are structural issues that hinder children and families in Mississippi from obtaining the appropriate health care coverage. Certain program requirements however, create struggles for all children/families to enroll into programs for health services, particularly Medicaid and CHIP services. These requirements include:

- a) **Face-to-Face Requirement for Medicaid Certifications and Re-Certifications:** There was a consensus amongst service providers that the requirement of parent(s) having to participate in a face-to-face meeting for Medicaid certifications (and recertification) deterred children/families from enrolling. Many parent(s) are not able to attend scheduled meetings, for reasons such as transportation, paperwork organization, job/work commitments, and child-care issues. Mississippi is the only state that has this requirement for both Medicaid and CHIP at the initial application stage and the renewal phase.<sup>3</sup>
- b) **Service Limitations and Prior Authorizations:** Many of the Medicaid benefits that are available to children restrict the annual limits on services. This caps the quantity of provider services that are eligible for reimbursement within a year. Children with medical/health issues may be unable to receive amount of patient visits and doctor appointments needed to address their need (some benefits provide extra services, per prior authorization approvals).

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<sup>3</sup> New York requires a face-to-face meeting at the time of Medicaid enrollment, not renewal, but counts community-based application assistance as meeting this requirement. Tennessee requires a face-to-face meeting for enrollment in and renewal of Medicaid, not CHIP. See Donna Cohen Ross and Caryn Marks, “Challenges of Providing Health Coverage for Children and Parents in a Recession,” Kaiser Commission on Medicaid and the Uninsured, January 2009.

Historically, the requirements for prior authorizations were not significantly burdensome for providers. It was emphasized by stakeholders that the requirements related to gathering background information and validating clients’ needs has created an additional burden for service providers to address. Particularly Community Mental Health Centers (CMHCs) noted that prior authorizations tend to delay services and create unnecessary workloads. This is especially troubling for young children with “mildly severe”<sup>4</sup> cases, who may not be able to access services due to the inability to satisfy prior authorization requirements.

Due to the issues noted above, and other factors, the state’s participation rate in key programs is not comparable to other states, even though there is a considerable population of low-income children/families that are presumably eligible for services. In comparison to other states, MS participation rate for children in Medicaid and CHIP is relatively close to the national average ((Nationwide: 84.8% Range Across States: 62.9% - 96%)<sup>5</sup>:

**Table 3. Medicaid/SCHIP Participation Rates**

1	Massachusetts	96.0%
2	Arkansas	92.8%
3	Vermont	92.4%
4	Michigan	92.1%
5	Hawaii	91.8%
6	Delaware	91.7%
7	Maine	91.5%
8	Rhode Island	90.9%
9	Illinois	90.8%
10	Connecticut	90.7%
11	West Virginia	90.5%
12	New York	90.4%
13	Kentucky	90.0%
14	Nebraska	90.0%
15	Tennessee	90.0%
16	Alabama	89.6%
17	Louisiana	89.5%
18	Maryland	89.4%
19	Wisconsin	88.5%
20	Pennsylvania	88.4%
<b>26</b>	<b>Mississippi</b>	<b>85.4%</b>

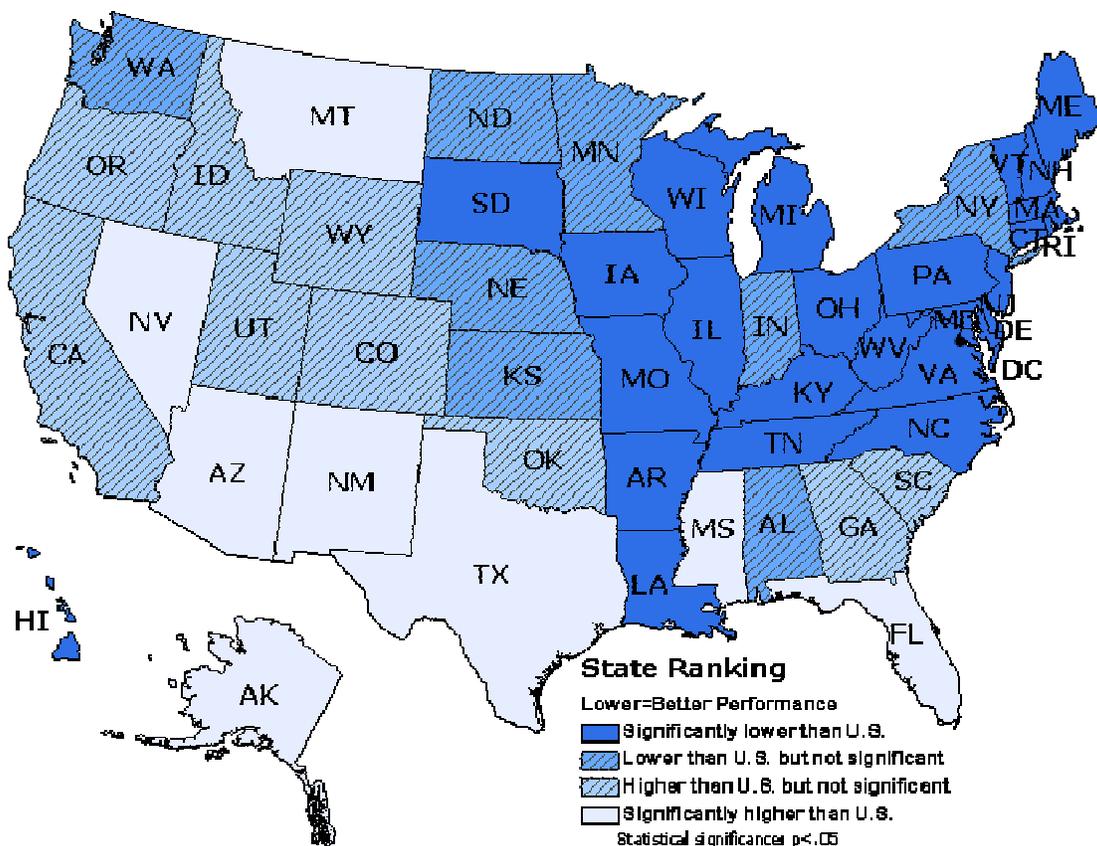
<sup>4</sup> Mildly severe cases refers to the children who demonstrate intermediate symptoms, but may not fully meet the authorization requirements for services.

<sup>5</sup> Reports and Data: Medicaid/CHIP Participation Rates, InsureKidsNow.gov, 2011.

However, based on the current population of low-income families in Mississippi, there should be a larger pool of eligible enrollees. Additionally, the current program barriers also create inconsistencies amongst children maintaining the appropriate health insurance coverage. It was reported that nearly 60 percent of individuals up for annual renewal fail to appear for the face-to-face interviews and nearly 90 percent of “new” applications that Mississippi approve for children/families are those whose coverage had previously lapsed.<sup>6</sup> Many of the children/families that are able to obtain health insurance coverage struggle to satisfy annual requirements and ultimately fail to maintain the adequate coverage for health services.

The Data Resource Center for Child and Adolescent Health assessed each state’s child population to measure various health factors. It was determined that Mississippi’s children lacked consistent insurance coverage significantly in comparison to other states, illustrated in the state ranking map below<sup>7</sup>:

**Map 1. Insurance Coverage Consistency; Percent of children lacking consistent insurance coverage in the past year.**



<sup>6</sup> “Losing Ground: Declines in Health Coverage for Children and Families in Mississippi,” the Mississippi Center for Justice and the Mississippi Health Advocacy Program, Fall 2007.

<sup>7</sup> 2007 National Survey of Children’s Health. Data Resource Center for Child and Adolescent Health

### Access to Primary Care

To adequately address the health needs of the early childhood population, young children need to be able to access primary health care services. The network of available health professionals in Mississippi creates a challenge to sufficiently provide health services to young children. It is well documented that there are areas across the state that lack the needed medical professionals to cover the areas' demand. This presents problems for children and families seeking services, especially when there is a need for specialized services. Specific barriers for Mississippi's provider network are:

- a) Ratio of 1:579 of pediatricians to persons under 5 years
- b) Only 51 percent of licensed pediatricians in the state are Mississippi Cool Kids (EPSDT) providers.
- c) Out of 82 counties within the state, there are 38 counties that currently do not have a pediatrician, which is 46 percent of the counties.

According to the 2011 U.S. Census estimates, there are 210,913 persons under 5 years of age in Mississippi.<sup>8</sup> There are currently 364 licensed Pediatricians in the state.<sup>9</sup> This is a ratio of 1:579 for persons under the age of five. Out of the 364 licensed Pediatricians in the state, 280 currently are providers with an open Mississippi Medicaid provider number. This does not mean that the provider is available to accept Medicaid beneficiaries. Providers with an open Medicaid provider number may not be accepting new patients, may not have notified the Division of Medicaid to close their provider numbers, and for a variety of other reasons may not be accepting patients. Out of the 280 providers with an open Mississippi Medicaid provider number, there are only 188 of them that are Mississippi Cool Kids (EPSDT) providers.<sup>10</sup>

The following map illustrates by Mississippi counties:

- Number of persons under 5
- Pediatricians
- Pediatricians with an open Mississippi Medicaid provider number
- Pediatricians that are Mississippi Cool Kids (EPSDT) providers

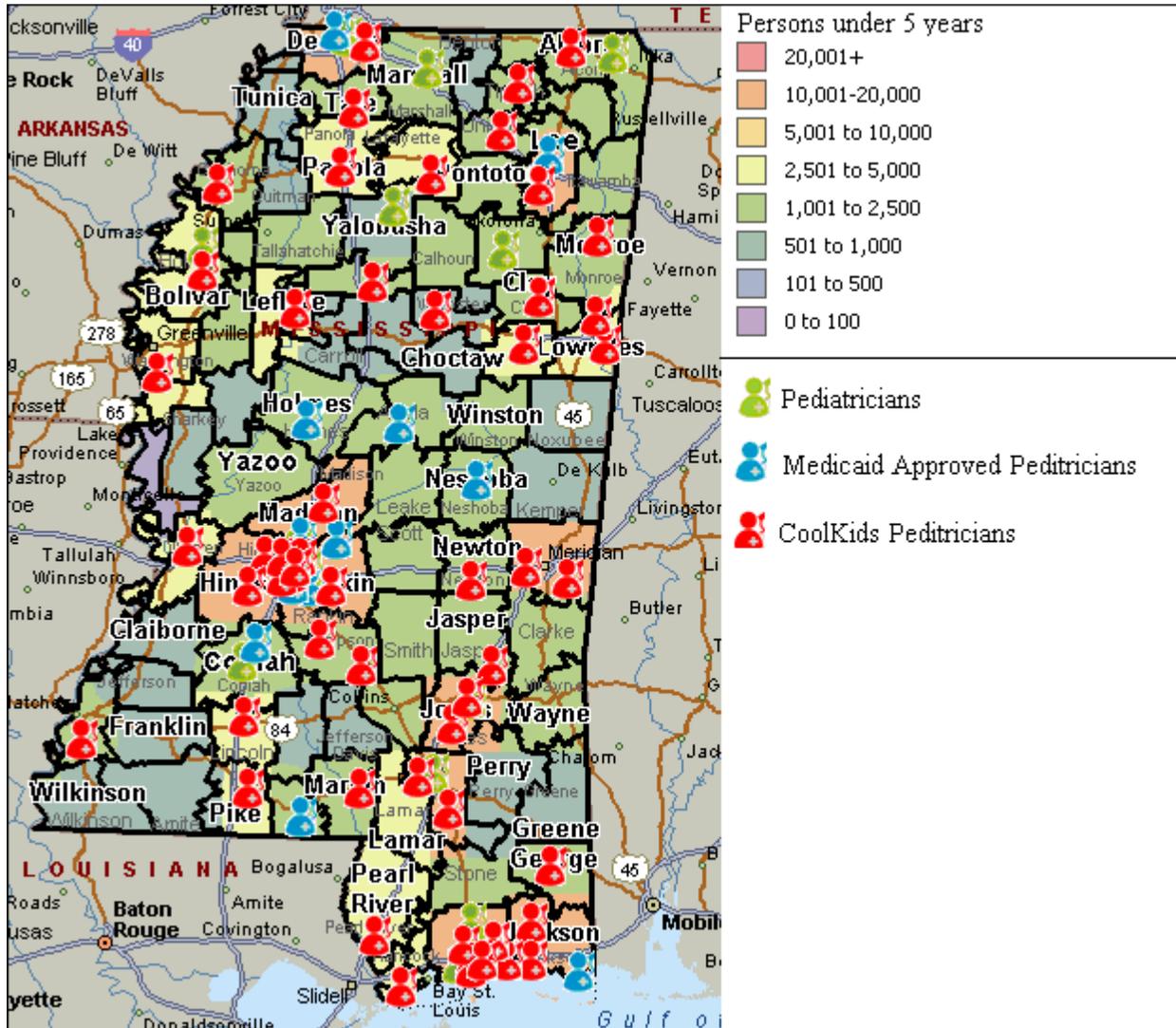
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<sup>8</sup> *United States Census Bureau*. Retrieved May 29, 2012, from United States Census Bureau State and County Quick Facts: [<http://quickfacts.census.gov/qfd/states/28000.html>]

<sup>9</sup> Mississippi Board of Medical Licensure. July 3, 2012

<sup>10</sup> *Mississippi Envision*. Retrieved June 12, 2012, from Mississippi Division of Medicaid:[ <https://msmedicaid.acs-inc.com/msenvision/ProviderLocatorInquirySubmit.do>]

**Map 2. Pediatricians in Mississippi Counties<sup>11</sup>**

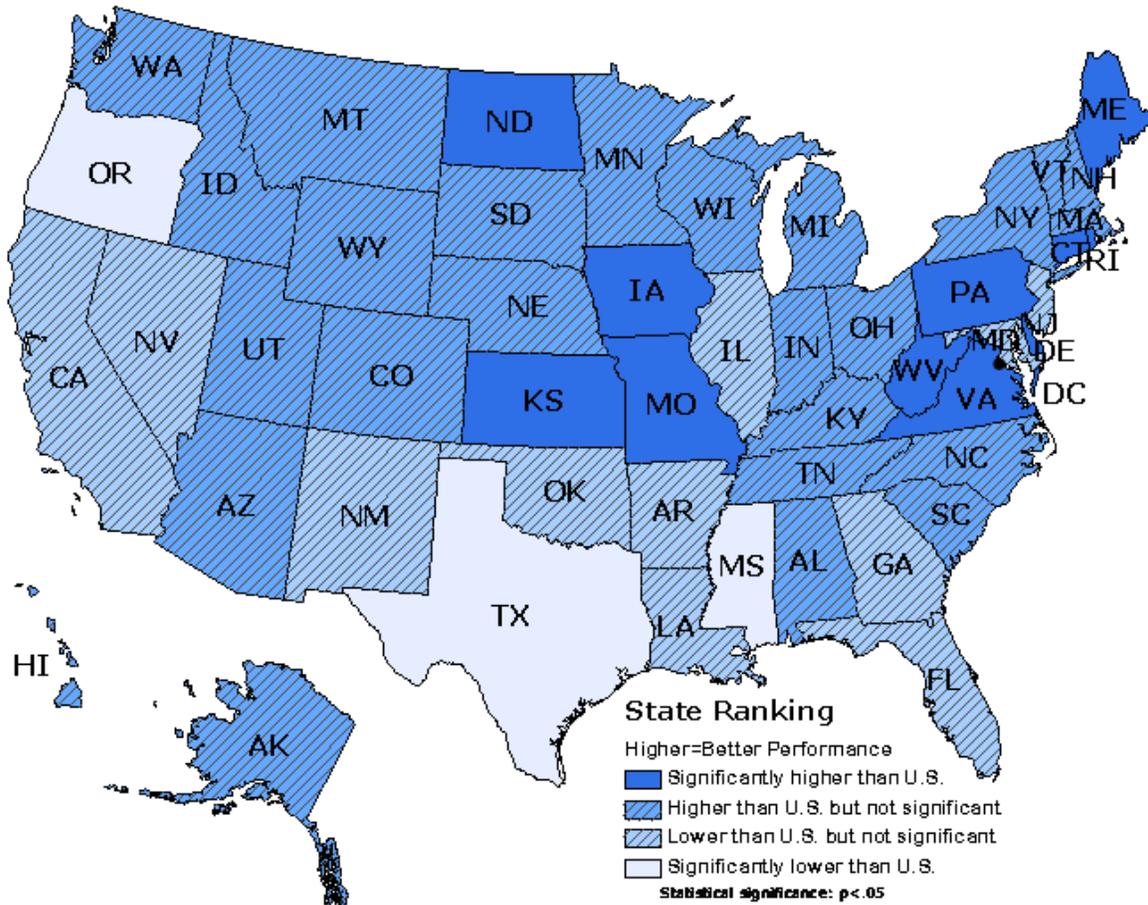


<sup>11</sup> Mississippi State Board of Licensure, Roster of Licensed Physicians, June 2012; [\[https://www.ms.gov/medical\\_licensure/renewal/main.jsp\]](https://www.ms.gov/medical_licensure/renewal/main.jsp), Mississippi Envision, Medicaid Provider Search; [\[https://msmedicaid.acs-inc.com/msenvision/providerSearch.do\]](https://msmedicaid.acs-inc.com/msenvision/providerSearch.do), United States Census Bureau, State and County, Mississippi, People QuickFacts; [\[http://quickfacts.census.gov/qfd/states/28000.html\]](http://quickfacts.census.gov/qfd/states/28000.html)

Access to Mental Health Care

The health needs of the early childhood population incorporate more than their physical health, but also the mental health needs as well. It is significantly important for children to receive services for diagnosed emotional disorders and other identified mental issues. Mississippi has been proactive in addressing the mental health needs of children, which stakeholders acknowledged throughout our review. There are still issues with connecting children to the needed mental health services. Based on the 2007 study by the Data Resource Center for Child and Adolescent Health, the percentage of children in Mississippi with problems requiring counseling who receive MH services is significantly lower than other states. This point is illustrated in the state ranking map below<sup>12</sup>:

**Map 3. Mental Health Care; Percent of children with problems requiring counseling who received mental health care (age 2-17)**

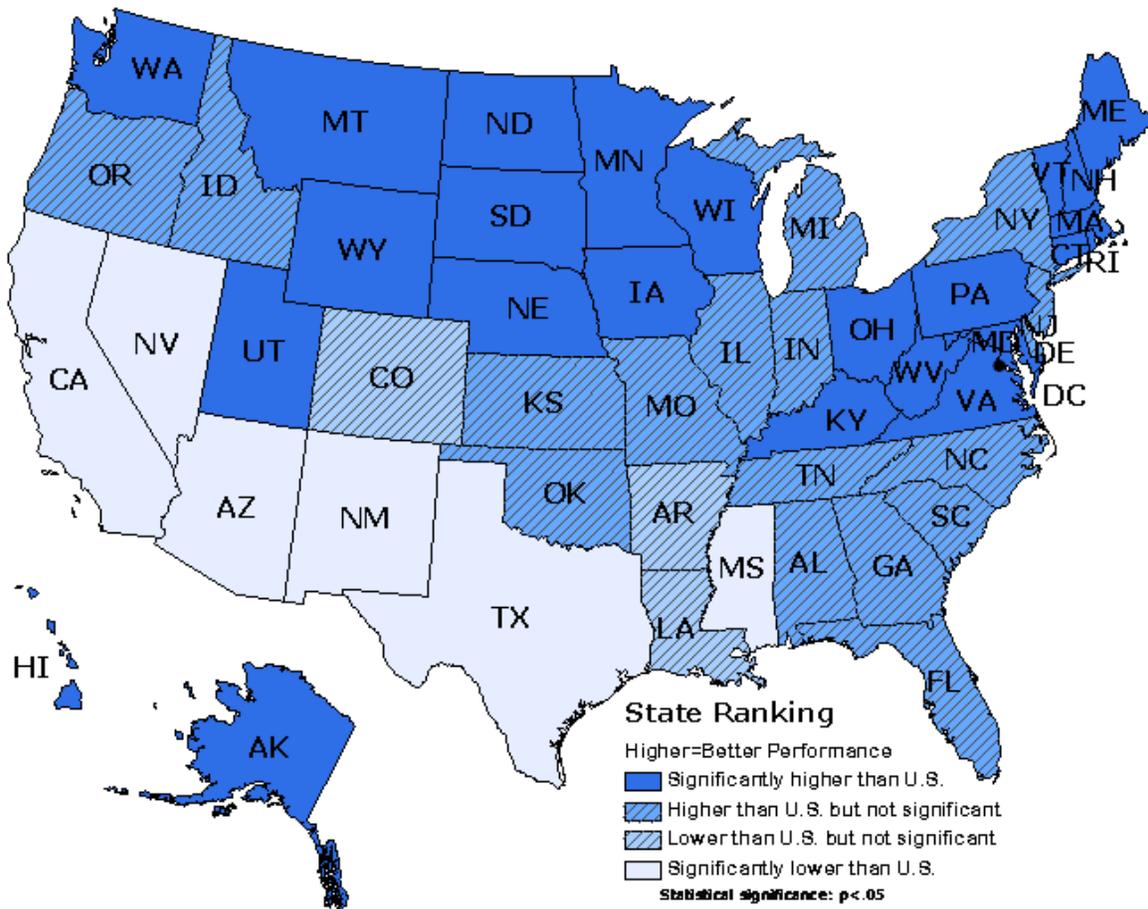


<sup>12</sup> 2007 National Survey of Children’s Health. Data Resource Center for Child and Adolescent Health.

Access to Dental Care

Mississippi currently does not have a strong network of dental service providers to fully serve the early childhood population. Subsequently, the overall oral health of children in the state is suffering. Mississippi ranked as one of the lowest states in regards to the percent of children in excellent or very good oral health. As identified in the following illustration the state ranks significantly lower than the rest of the country<sup>13</sup>:

**Map 4. Dental Care; Percent of children in excellent or very good oral health (age 2-17)**



The most significant barrier to access of dental services is the number of dentists in the state. The chart below provides a snapshot of the *entire landscape of Mississippi's dental workforce*.<sup>14</sup>

<sup>13</sup> 2007 National Survey of Children's Health. Data Resource Center for Child and Adolescent Health.

<sup>14</sup> The National Center for Chronic Disease Prevention and Health Promotion, Oral Health Resources, Synopses by State. <http://apps.nccd.cdc.gov/synopses/StateDataV.asp?StateID=MS&Year=2009>

**Table 4. Oral Health Workforce**

<b>Total Number of Oral Health Providers</b>	
Number of dentists in the state	1,193
Number of dental hygienists in the state	1,071
Number of counties without a dentist.	4 of 82 counties
<b>Medicaid Enrolled Oral Health Providers</b>	
Number of counties in state without an enrolled Medicaid dentist	5 of 82 counties
Number of dentists with at least one paid claim - Medicaid only.	484
Number of treating dentists with at least 1 claim - Medicaid	484
Number of billing providers who saw 50 or more beneficiaries < 21 years - Medicaid	331
Number of billing providers who saw 100 or more beneficiaries < 21 years - Medicaid	276

Many of the stakeholders we have interviewed or communicated with emphasized that one of the major factors that has led to poor oral health in young children is the state’s extreme need for pediatric dentists across the state. Pediatric dentists, especially those that serve the early childhood population are unique in that their specialty allows them to better serve the oral health needs of young children. Many general dentists serve entire families or patients of all ages and often do not feel comfortable meeting the specialized needs of children birth to age five. Currently, there are only fifty five licensed pediatric dentists in the state and an estimated 210,913 persons under 5 years old; this mean the ratio of young persons under 5 years old to pediatric dentists is 1: 3,835.<sup>15</sup>

The most recent MS Oral Health Survey of third graders conducted in 2010 found that young children’s most common oral health problem is tooth decay<sup>16</sup>. The study also found that outcomes for minority children were much lower than that of their counter-parts; Non-Hispanic black children have poorer oral health status in comparison to Non-Hispanic white children. Please note that children in third grade were surveyed as a proxy for the oral health of young children due to the fact that during this age children have typically developed their sixth year molars. The assessment of sixth year molars can provide an indication of the presence of periodic check-ups or dental services prior to that age.

In addition to the shortage of pediatric dentists, Mississippi’s low-income young children also face the barrier of having access to few providers that accept Medicaid or CHIP. The reasons for this gap in providers varies; some stakeholders believed that many dentists/dental specialists did not desire to deal with Medicaid or CHIP programs due to paperwork and additional costs while

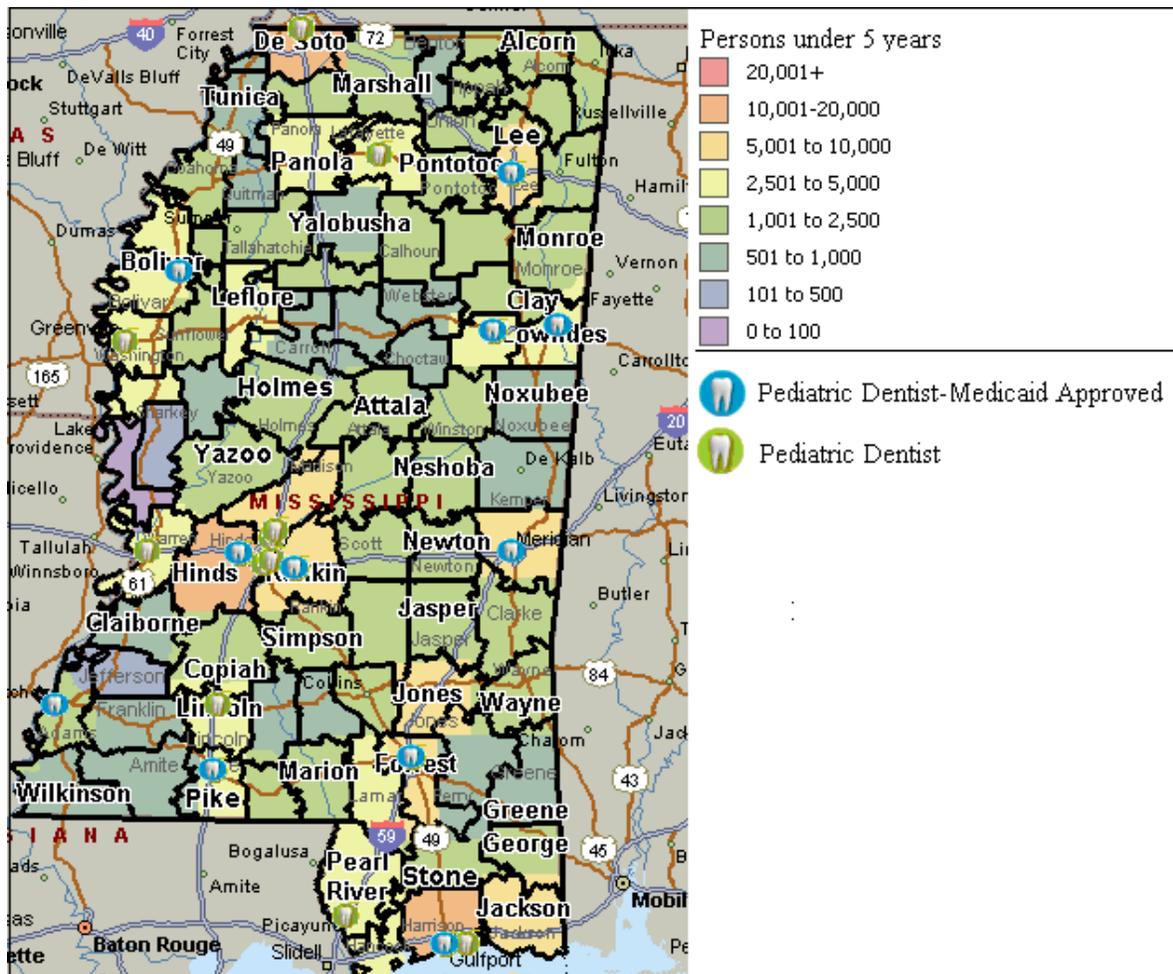
<sup>15</sup> Data on persons under 5 data from U.S. Census bureau [<http://quickfacts.census.gov/qfd/states/28000.html>]

<sup>16</sup> “The Oral Health of Mississippi’s Third Grade Children 2009-2010 School Year,” Every Smile Counts, Mississippi State Department of Health, Health Services, Office of Oral Health [<http://www.dentalboard.ms.gov/msbde/msbde.nsf/>]

others have experienced lack of payments for services and opt not to serve low-income families. Of the forty licensed pediatric dentists in the state only 37.5% participate in Medicaid<sup>17</sup>. It was also noted that the rate structure was not encouraging for recruiting private dentists. Regardless of the issues affecting the network of providers, there is clearly a lack of available dental providers for children/families to access for services.

The following map displays the forty licensed pediatric dentists, those that are Medicaid approved and their geographic dispersion. As seen in the map, licensed pediatric dentists are spread across the state with many regions having few in close proximity.

**Map 5. Pediatric Dentists in Mississippi Counties**<sup>18</sup>



<sup>17</sup> Mississippi Envision, Medicaid Provider Search; See [<https://msmedicaid.acs-inc.com/msenvision/providerSearch.do>]

<sup>18</sup> Mississippi Board of Dental Examiners 9/01/2011, Licensed Pediatric Dentist Search; [<http://www.dentalboard.ms.gov/msbde/msbde.nsf/>], Mississippi Envision, Medicaid Provider Search; [<https://msmedicaid.acs-inc.com/msenvision/providerSearch.do>], United States Census Bureau, State and County, Mississippi, People QuickFacts; [<http://quickfacts.census.gov/qfd/states/28000.html>]

### Minority Disparities

Barriers to access for early childhood health care is even more prominent in minority populations both nationally and in Mississippi; “Among uninsured children, Black children are almost 60 percent more likely than White children to have an unmet medical need. Latino children are more than 3 1/2 times more likely than White children to lack a regular place to receive health care.”<sup>19</sup> African American children in the state have a highly disproportionate percent of inadequate health insurance coverage; they are more likely to use hospital emergency rooms and clinics as their primary source of health care as compared to White Mississippians. The lack of health insurance is largely due to higher unemployment, especially in areas such as the Delta region of northwest Mississippi, the poorest economic section of the state. Therefore, African Americans are more likely to be Medicaid recipients.<sup>20</sup> A barrier to quality care comes from not only the lack of pediatric physicians in the state, but physician engagement with minority family and children during medical visits. In a recent study, published in “Patient Education and Counseling,” researchers conducted surveys in 23 community pediatric practices with a sample of 405 children and parents. The study found that disparity in patient engagement experienced by minority families were due to socioeconomic differences; low-income minority parents experience lower levels of physician engagement compared to higher-income families.<sup>21</sup> The study echoes the findings of previous studies which also found that physicians are less likely to engage minority patients. This finding suggests that there is a more complex relationship between race and ethnicity and the quality of care.

Mississippi’s Department of Health, Office of Minority Affairs, and Disparities Steering Committee released a statewide plan to eliminate racial and ethnic health care disparities in 2002.<sup>22</sup> Although, focused attention has led to great strides in partnerships between community-based contractors and the State Department of Health, minorities in the state still face barriers to health care access and the quality of care.

In addition to efforts by the Department of Health, research institutes such as the Mississippi Institute for the Improvement of Geographic Minority Health and Health Disparities (MIGMH), established through a competitive grant awarded by the Health and Human Services’ Office of Minority Health Research in September 2006 focuses on some of the key indicators of health status in Mississippi and targets mechanisms to increase the knowledge surrounding these conditions along with strategies to improve them.<sup>23</sup> Programs like MIGMH provide valuable medical resource guides, marketing and educational tools to provide targeted assistance to minority populations with little to no health insurance coverage.

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<sup>19</sup> “Improving Children’s Health- Understanding Children’s Health Disparities and Promising Approaches to Address Them.” Children’s Defense Fund. 2006

<sup>20</sup> Thompson, Ed; Denson, Louisa Young et al. Mississippi State Department of Health, Office of Minority Affairs “Mississippi’s Plan to Eliminate Racial and Ethnic Health Care Disparities” April 2002

<sup>21</sup> Cox ED, Nackers KA, Young HN, et al. Influence of race and socioeconomic status on engagement in pediatric primary care. *Patient Education and Counseling*. 2012 Jun; DOI: 10.1016/j.pec.2011.09.012

<sup>22</sup> “Mississippi’s Plan to Eliminate Racial & Ethnic Health Care Disparities.” Mississippi State Department of Health, Office of Minority Affairs, Disparities Steering Committee. Spring 2002

<sup>23</sup> Mississippi Institute for the Improvement of Geographic Minority Health and Health Disparities [http://www.migmh.com/]

### Other Barriers to Access

In addition to the program barriers we identified, many stakeholders noted that there is also a general inability to obtain services due to economic barriers. Many of the families with young children in Mississippi do not have the financial resources to access the needed health services. A universal issue that was identified is the lack of transportation, which is particularly burdensome of the Delta region. Due to the declined economy, there are families unable to find transportation to scheduled appointments, service centers and health facilities. In Mississippi, at least two in five young children (birth to age 5) are a part of low-income families.

## STATE BEST PRACTICES

### Health Insurance Coverage

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included many provisions designed to give states the tools they need to effectively enroll eligible children in Medicaid and the Children's Health Insurance Program (CHIP). A primary goal of the many outreach and simplification initiatives authorized by the CHIPRA is to reach the 7 in 10 uninsured children who are already eligible for Medicaid and CHIP.

Even prior to CHIPRA, many states understood the potential benefit of improving access to public health insurance programs by reaching and enrolling eligible but uninsured children in Medicaid and CHIP. In fact, following the authorization of CHIP in 1997 and the incentive it offered through enhanced federal matching funds, a number of states began pursuing efforts to link children into Medicaid and CHIP through targeted outreach and streamlined application and renewal processes, including cross-program enrollment efforts. Examples include:

- Since 2003, California has allowed children to use the school lunch application as a Medicaid application at participating schools. However, the program utilizes a two-step process. First, a family must submit the school lunch application. Children eligible for free lunch are evaluated for temporary Medicaid after submitting this form, where their family provides consent. However, to receive full coverage, the family must then complete a short supplemental form with additional information and documentation. An evaluation of three years of this effort found that only 40 percent of the children who received temporary coverage based on their school lunch application ended up receiving ongoing coverage, predominantly due to their failure to return the follow-up form.
- Louisiana has been utilizing a state-initiated Medicaid renewal process that relies on *ex parte* processes to obtain relevant information since 2001. When an enrollee comes up for renewal in Medicaid, Louisiana takes the initiative to retrieve relevant, current information from Food Stamp and cash assistance files in order to complete the renewal, rather than waiting for the family to start the renewal process. Today, about three-quarters of enrollees are renewed without completing a Medicaid renewal form. To date, this process has been completed manually by eligibility staff, but the state is currently automating the process so that it will no longer require staff time. Since implementing this initiative, Louisiana's Medicaid renewal denial rate for procedural reasons has dramatically fallen from over 25% to just 1%.
- Florida conducted an enrollment initiative between 2000 and 2003 in which childcare resource and referral agencies helped families complete a health care application. When the childcare eligibility worker checked a box on the electronic childcare application indicating that a family wanted to apply for health coverage, they were automatically prompted to ask an additional eight "yes or no" questions that were then used to complete a health coverage application. Childcare staff spent about five minutes to complete the

additional screen to submit a Medicaid application. Despite that added labor, the enrollment initiative received support from Florida's subsidized child care agency, and, therefore, the child care resource and referral agencies were committed to it as well and found the limited time investment to be worthwhile.

CHIPRA established "Performance Bonuses" for states to support the enrollment and retention of eligible children in Medicaid and CHIP. Performance Bonuses provide additional federal funding for qualifying states that have taken specific steps to simplify Medicaid and CHIP enrollment and renewal procedures and have also increased enrollment of children above a baseline level. The Performance Bonus is designed to help states with the added costs that result when states are very successful in enrolling eligible children in Medicaid above targets specified in the law. To be eligible for a Performance Bonus, states must first adopt at least five of the following eight measures for children, which generally are aimed at simplifying Medicaid enrollment and renewal for children:

#### 12-month continuous coverage

Continuous coverage (also known as continuous eligibility) guarantees a full 12 months of coverage for children enrolled in Medicaid and CHIP, regardless of changes in their financial circumstances. This is how job-based insurance that covers most Americans works. Continuous coverage promotes continuity of care by assuring that children do not lose coverage due to fluctuations in income, which tend to be small in any case. Similarly, it encourages managed care plans to participate in Medicaid and CHIP by ensuring more stable enrollment. Continuous coverage also reduces the costs to states that stem from "churning" the cycling of individuals in and out of the program. As of January 2012, 23 states had adopted continuous coverage for children in both Medicaid and CHIP.<sup>24</sup>

#### No asset test (or simplified asset verification)

To satisfy this requirement, state Medicaid and CHIP programs must either have no asset test for children or simplify their rules for verifying assets. States have long had the discretion under federal law to not impose an asset or resource test for Medicaid eligibility, and all but four states have adopted this approach for children. Because few low- and moderate income families have substantial assets, not requiring an asset test does not necessarily expand eligibility, but it does relieve both families and states of the paperwork burden involved in documenting assets.

#### Joint application and the same information verification process for separate Medicaid and CHIP programs

Most states with separate Medicaid and CHIP programs use a joint application form, but this measure goes beyond the application form to require states to use the same renewal and supplemental forms (if any) and the same process for verifying information in both programs. There are many advantages to using the same simplified process in both

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<sup>24</sup> "Medicaid and CHIP Programs". Georgetown University Health Policy Institute, Center for Children and Families.

programs. Uniformity makes it easier for families (and groups working with families) to understand the procedures and helps prevent children from slipping through the cracks in a system with two coverage programs for children. Not all states that have adopted simplified enrollment and renewal processes in CHIP have carried over those procedures to Medicaid, so it remains harder for lower-income Medicaid-eligible children to enroll or renew their coverage. Research demonstrates that simplifying the process for Medicaid can not only promote enrollment and retention, but, by supporting stable coverage, also reduce costly hospitalizations.<sup>25</sup>

#### Administrative or *ex parte* renewals

There is abundant evidence that many children lose coverage at renewal time, and that administrative renewals can boost participation of eligible children while reducing state administrative costs.<sup>26</sup> The term “administrative renewals” generally refers to a process by which states attempt to renew eligibility based on information available to them, for example, through other program records or data bases. States can satisfy this measure in different ways. The new CHIP law describes a process whereby the state would send a pre-printed form with the most current information available to the state and require the parent or caretaker to report any changes. If there are no changes, eligibility is renewed and coverage continues. The law also provides that a state using an *ex parte* process will be deemed to have met this requirement. *Ex parte* reviews occur when the state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. Federal law requires neither a renewal form nor a signature to confirm ongoing eligibility under either Medicaid or CHIP.

#### No face-to-face interview requirement

Federal law does not require face-to-face interviews at the time of application or renewal in either Medicaid or CHIP. As of January 2009, only two states required an interview for new child applicants and just one state (Mississippi) required an interview at renewal. Requiring parents who often lack flexibility to leave work to appear in person to apply for or renew coverage for their children makes it more difficult for parents to seek or retain that coverage. Families that find it helpful to apply for or renew coverage in person still have an opportunity to do so through the state agency (or CHIP contractor) and, in some states, at other community-based locations.

#### Presumptive eligibility

Presumptive eligibility allows states to authorize health care providers, community-based organizations, schools, and other entities (as determined by the state) to screen for Medicaid and CHIP eligibility and make temporary eligibility determinations. It gives community-based outreach and enrollment assisters a powerful tool to reach eligible children and to provide the direct help that some families need to understand and

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<sup>25</sup> L. Ku, “New Research Shows Simplifying Medicaid Can Reduce Children’s Hospitalizations,” Center on Budget and Policy Priorities (September 2007).

<sup>26</sup> B. Morrow and D. Horner, “Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices,” The Children’s Partnership and The Kaiser Commission on Medicaid and the Uninsured (May 2007).

complete the application process. Most importantly, it ensures that children can get medical care right away while the final eligibility decision is pending. In addition to making the application process easier for families, if the presumptive eligibility enrollers also help families gather necessary documentation, presumptive eligibility can reduce the administrative burden on the state to obtain missing information.

#### Express Lane eligibility

Express Lane eligibility is a new federal option created by CHIPRA that allows states to use eligibility for other public programs (such as TANF, Food Stamps, Head Start, WIC, school lunch, and more) to determine that a child satisfies one or more components of eligibility for Medicaid or CHIP. For the first time, states may rely on the findings of the other public programs, without regard to relatively small differences in program methodologies for determining, for example, household size or income. Express Lane eligibility is a promising strategy to help states find and quickly enroll children and avoid unnecessary and repetitive requests for information that can add to the paperwork burden for both families and states. Some states have successfully used express-lane-like processes to identify potentially eligible children. Until federal guidance is issued, it is not clear exactly what criteria will be used to determine whether a state has implemented this new option in a way that qualifies for the Performance Bonus.

#### Offer a premium assistance option

The final measure that can be used to qualify for the performance bonus is to offer a premium assistance option. Premium assistance offers states a way to subsidize qualified group health and employer-sponsored coverage using Medicaid or CHIP funds. While it is generally not considered a strategy to enroll and retain children, premium assistance can be a useful strategy for combining employer and public funding for coverage. It was included as one of the eight measures because interest in premium assistance among some policymakers remains high. Overall, enrollment in premium assistance programs is limited, largely because only a relatively small number of families with uninsured children have access to cost-effective private coverage. A separate provision in the CHIP law offers states a new option that will make it easier to implement premium assistance in CHIP. The new law also includes some provisions that will help states obtain needed information from employers about the coverage they offer and coordinate well with employers' open enrollment periods.

CMS awarded nearly \$300 million in FY 2011 CHIPRA Performance Bonuses to 23 states in every region across the country. The amount of the award correlates with the percentage increase in Medicaid enrollment above the baseline—the more children states enroll, the higher the bonus and states that increase enrollment more than 10 percent above the baseline receive an even larger (“Tier 2”) bonus. States that qualify for bonuses have used various strategies to enroll more children. They include cutting red tape and streamlining procedures so families can more easily enroll their children in health coverage and keep them covered for as long as they are eligible.

States also are continuing their efforts to streamline and improve the efficiency of their Medicaid and CHIP programs. All states that received a Performance Bonus in 2010 qualified again for 2011. Five states (Illinois, Iowa, New Jersey, New Mexico, and Oregon) now have six (6) of the eight (8) possible program features in place. Seven of the states receiving bonuses this year are newly qualifying states. These seven states that qualified for performance bonuses for the first time this year implemented a variety of new program features including presumptive eligibility, Express Lane Eligibility and premium assistance subsidies. Please see Appendix B for a full listing of states' CHIPRA Bonuses from FY2009 through FY2011.

Outreach and administrative simplification measures that help states qualify for the CHIPRA Performance Bonuses are best practices to be considered to promote a positive long-term impact on access to health insurance coverage and continuity of care into the future. Recent results from the National Center for Health Statistics show that the number of children with health insurance has continued to climb over the past 3 years, since the reauthorization of the CHIP in February 2009,<sup>27</sup> while the number of children in public health insurance coverage through Medicaid and CHIP grew by 5.4 percent since 2009.<sup>28</sup> Two of the specific practices driving increased access presented for consideration are detailed below.

### ***Express Lane Eligibility***

One of the key tools that CHIPRA created is the Express Lane Eligibility (ELE) option. ELE provides states with important new avenues to ensure that children eligible for Medicaid or CHIP have a fast and simplified process for eligibility determination or renewal. States may rely on eligibility information from "Express Lane" agency programs to streamline and simplify enrollment and renewal in Medicaid and CHIP. As specified by section 203(a) of CHIPRA, Express Lane Agencies (ELAs) are entities identified in the state plan by the state Medicaid or CHIP agency as being capable of making a finding regarding one or more programmatic eligibility requirements, using information the ELAs already collect. A state's Medicaid and CHIP program may use different ELAs and may select more than one agency. ELAs may include Supplemental Nutrition Assistance Program (SNAP), School Lunch, Temporary Assistance for Needy Families, Head Start, and Women, Infant, and Children's program (WIC) among others. States can also use state income tax data to determine eligibility for children.

A state may use a finding from an Express Lane agency made within a reasonable period of time (as defined by the state), for any Medicaid or CHIP eligibility factor without regard to differences in budget unit, income disregards, deeming, or other differences in methodology between the Express Lane agency and Medicaid or CHIP. For example, a state may use an income finding from an Express Lane agency that uses either gross or adjusted gross income obtained from state income tax records or returns. (As noted above, a state may also obtain this information directly from state income tax records or returns.)

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<sup>27</sup> HHS Office of the Assistant Secretary for Planning and Evaluation Issue Brief, "1.2 Million Children Gain Insurance Since Reauthorization of Children's Health Insurance," December 2011.

<sup>28</sup> G. Kenney, V. Lynch, J. Haley, M. Huntress, D. Resnick, and C. Coyer, "Gains for Children: Increased Participation in Medicaid and CHIP in 2009," The Urban Institute, August 2011.

Since the Express Lane agency’s methods of calculating income may result in a determination that the family’s income is higher than it might be using regular Medicaid or CHIP methods, states using the ELE option are required to conduct a full eligibility determination if a child is found ineligible for Medicaid and CHIP using an ELE finding to ensure that the child is not eligible under regular program rules. Families in these situations must be informed if additional information is required and be given the opportunity to provide it. States can use eligibility information from ELE agency programs to simplify the enrollment process, such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), and the School Lunch program. Listed in the chart below are seven states using Express Lane Eligibility to facilitate enrollment.<sup>29</sup>

**Table 5. States with Express Lane Eligibility Practices**

State	Program	State Plan Amendment	Express Lane Agency	Eligibility Determination	
				Initial	Renewal
		<b>Effective Date</b>			
<b>Alabama</b>	Medicaid	10/1/2009 4/1/2010	SNAP TANF	<b>X</b> (4//1/10)	<b>X</b> (10/1/09)
<b>Iowa</b>	Medicaid	6/1/2010	SNAP	<b>X</b>	
<b>Hawaii</b>	<i>State Plan Pending for Medicaid</i>				
<b>Louisiana</b>	Medicaid	10/10/2009	SNAP NSLP	<b>X</b>	<b>X</b>
<b>New Jersey</b>	Medicaid	5/1/2009	Division of Taxation	<b>X</b>	<b>X</b>
<b>Maryland</b>	Medicaid	4/1/2010	Office of the Comptroller (income tax)	<b>X</b>	
<b>Oregon</b>	Medicaid CHIP	8/1/2010	SNAP NSLP	<b>X</b>	
<b>Total</b>	<b>Medicaid-5</b>			<b>6</b>	<b>3</b>
	<b>CHIP-3</b>				

***Presumptive Eligibility***

Many uninsured children have unmet health care needs. However, when they apply for health coverage through Medicaid and CHIP, they often have to wait for over a month before their application is processed and their parents can make doctors’ appointments. “Presumptive eligibility” can help children get needed care right away. Presumptive eligibility provides

<sup>29</sup> “Express Lane Eligibility for Medicaid and CHIP Coverage”. InsureKidsNow.gov, Connecting Kids to Coverage.

children immediate access to health services by giving them temporary health insurance through Medicaid or CHIP if they appear to be eligible.

Children can be determined presumptively eligible by organizations that provide other services to low-income families. States may authorize “qualified entities” to screen for Medicaid and CHIP eligibility and immediately enroll eligible children. In selecting organizations or individuals to make presumptive eligibility determinations, states may choose from health care providers participating in Medicaid, schools, organizations that determine eligibility for Head Start, WIC, and the Child Care and Development Block Grant program, and child support enforcement agencies, among others. The entities identify children they are already serving who are uninsured and who are likely to be eligible for Medicaid or CHIP and compare the family income of those children to eligibility levels for children’s health coverage under Medicaid or CHIP. If it looks like the child is eligible, the family is given a card or a letter providing access to temporary health care coverage until an official eligibility determination is made. A complete application for Medicaid and/or CHIP must be filed by the end of the next month following the date the presumptive eligibility period begins.

Presumptive eligibility lets children receive Medicaid or CHIP services without waiting for their application to be fully processed. Qualified entities can also help families gather documents to complete the full application process, reducing the administrative burden on states to get missing information. Children can get health services immediately, instead of waiting several weeks for paperwork to be processed. Families are much more likely to seek care when they have insurance. Delays in obtaining care can lead to dangerous and expensive emergency situations.

There are sixteen (16) states that use presumptive eligibility to enroll children in Medicaid and/or CHIP programs. As of January 2009, eleven (11) states had adopted presumptive eligibility for children in both their Medicaid and CHIP programs. The following chart displays the states using presumptive eligibility for either Medicaid or CHIP.<sup>30</sup>

**Table 6. States with Presumptive Eligibility Practices**

STATE	CHIP	Medicaid
California	✓	✓
Colorado	✓	
Connecticut		✓
Illinois	✓	✓
Iowa	✓	✓
Kansas	✓	✓
Massachusetts	✓	✓
Michigan	✓	✓

<sup>30</sup> “Presumptive Eligibility for Medicaid and CHIP Coverage”. InsureKidsNow.gov, Connecting Kids to Coverage.

STATE	CHIP	Medicaid
Missouri		✓
Montana	✓	✓
New Hampshire		✓
New Jersey	✓	✓
New Mexico	✓	✓
New York	✓	✓
Ohio	✓	✓
Wisconsin		✓

States have many reasons to adopt these strategies beyond qualifying for the CHIPRA Performance Bonus. Most of the measures have proven to be effective in increasing enrollment and retention of eligible children. Better enrollment and retention, in turn, promote children’s access to preventive care and improvements in the quality of care and health outcomes. In addition, streamlining enrollment and retention processes may reduce state administrative burdens and costs.

### Access to Primary Care

Having a medical home has been shown to impact access and use of medical and dental care. A significantly greater percentage of children without a medical home have an unmet health care need, do not receive routine preventive care, and go without access to a routine source of care. The same association exists between absence of a medical home and dental care. There are also significant disparities in receipt of care in medical homes by race and ethnicity and poverty.<sup>31</sup> In every state, assuring access to health care and a medical home was a core component of the Early Childhood Comprehensive System (ECCS) initiative. This approach is particularly relevant as Medicaid finances health, mental health, and developmental services for approximately one-third of U.S. children under age 6.<sup>32</sup>

The primary care medical home, sometimes referred to as a patient-centered medical home (PCMH), advanced primary care, or health home, is being touted as a promising model in public health insurance programs and among commercial payers. This interest in the medical home model has much to do with promising data that link medical homes to improvements in access to care, as well as quality outcomes, patient and family experience, and provider satisfaction.

A medical home is a source of comprehensive primary care that provides services ranging from preventive care to management of chronic illnesses. Medical homes promote a trusting, ongoing relationship between patients and their primary care providers, helping patients to manage their health care better. Ideally, medical homes use integrated data systems and performance reporting

<sup>31</sup> American Academy of Pediatrics. 2012. See [<http://www.aap.org>]

<sup>32</sup> National Center for Children in Poverty. “Maximizing the Use of EPSDT to Improve the Health and Development of Young Children.” Short Take No.2, 2006.

to continuously improve access to and quality of care, as well as communication with patients and other providers. In 2007, the national physician societies most involved in primary care agreed on characteristics that define a medical home.<sup>33</sup>

- Each patient has an ongoing relationship with a primary care physician.
- The physician leads a team that collectively takes responsibility for patients.
- The physician takes a whole-person orientation, providing preventive services as well as care for both chronic and acute illnesses.
- Care is coordinated and facilitated by information technology.
- Care is of high quality; for example, it follows evidence-based care guidelines.
- Patients have enhanced access to care through systems such as open scheduling and expanded hours.
- Payment recognizes the added value that medical homes provide to patients.

Medical homes show early promise for improving care delivery and bending the cost curve.

**A family-centered medical home is not** a building, house, hospital, or home healthcare service, but rather an approach to providing comprehensive primary care. **In a family-centered medical home** the pediatric care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the patient are met. Through this partnership the pediatric care team can help the family/patient access, coordinate, and understand specialty care, educational services, out-of-home care, family support, and other public and private community services that are important for the overall health of the child and family.

In 2009, the National Academy for State Health Policy (NASHP) created the Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program (CHIP) Participants, which is comprised of eight state teams (Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia). These states worked together during this one-year program, with the support of NASHP through a grant from The Commonwealth Fund, to develop and implement policies that increase Medicaid and CHIP program participants' access to high performing medical homes.

In March 2011, fifteen states joined NASHP's 3rd State Consortium to Advance Medical Homes in Medicaid and CHIP, supported by The Commonwealth Fund. Alabama, Colorado, Maryland, Massachusetts, Michigan, Minnesota, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Vermont and Washington will continue the progress made in the first two Medical Home consortia by engaging each other in learning communities designed to strengthen, sustain and expand current initiatives.

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<sup>33</sup> American College of Physicians. "Joint Principles of the Patient-Centered Medical Home," 2007.

Available at [<http://www.medicalhomeinfo.org/Joint%20Statement.pdf>]. The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association jointly released these principles in March 2007; together, these organizations represent approximately 333,000 physicians.

Many states are hoping their medical home projects will improve access to and increase appropriate use of primary care. For example, Oklahoma saw complaints to the agency about access to same-day or next-day care decrease from 1,670 in 2007 (the year prior to medical home implementation) to 13 in 2009 (the year following implementation). A 2009 study found that 72 percent of children in Colorado's medical home practices had well-child visits, compared with 27 percent of children in control practices. States are also seeing decreases in acute care utilization, especially avoidable hospitalizations and emergency department visits. Some state medical home initiatives are now reporting cost savings, largely because of averted acute care utilization.

Since 1998, North Carolina has paid primary care practices \$2.50 per Medicaid patient per month above normal fees to coordinate patient care. In addition, it has paid \$3 per patient per month to network offices to provide case management across multiple practices. One analysis indicated this program saved the state as much as \$124 million in 2004. According to an analysis prepared by Treo Solutions, Community Care of North Carolina saved nearly \$1.5 billion in costs between 2007 and 2009.

Vermont's Blueprint for Health has seen cost savings in the longest-running pilot community, St. Johnsbury. Their overall per-person per-month costs for commercially insured individuals decreased by approximately 12 percent from 2008 to 2009. The second Blueprint for Health community, Burlington, has shown an increase in costs of less than 1 percent over the same period.

An evaluation of the Colorado Medical Home Initiative found a 21.5 percent reduction in median annual costs for children with a medical home (\$785, compared with \$1,000 for non-PCMH children) in 2009. Oklahoma reported a decline in per capita expenses of \$29 per patient per year from 2008 to 2010.

### **Access to Mental Health Care**

Due to its broad federal mandate for coverage of Medicaid reimbursable services for individuals under age twenty-one, EPSDT is often suggested as the solution for coverage of any and all Medicaid services for young children. EPSDT has remained a central component of Medicaid because of the operational and financial capacity it gives states to create appropriate access to pediatric health care.

EPSDT law requires coverage of medically necessary treatment services. If a service has been approved as a Medicaid service under federal law and qualifies for federal matching funds, it is a covered service under EPSDT. In other words, for an individual child, a service is covered if it is determined (by a provider, managed care organization, or the state) to be medically necessary. How the service is defined and who determines medical necessity varies from state to state. One of the strengths of EPSDT is its use of a developmental standard of medical necessity. Generally, however, medically necessary care must be consistent with standard accepted practice to: (1)

help restore or maintain health; (2) prevent deterioration or ameliorate a condition; or (3) prevent the likely onset of a health problem.

In theory, EPSDT guarantees children coverage for the full range of screening, diagnostic, and medically necessary treatment services. In practice, however, screening and referral rates fell short of the 80 percent screening performance benchmark set in 1989 under the last major federal law changes to the program.

While most states' periodicity schedules call for two or three visits for toddlers in this age group, only a small number of states had reached the 80 percent performance goal for even one visit. Seven states (Illinois, Massachusetts, Missouri, Minnesota, Nevada, Iowa, and Michigan) reported an EPSDT participation (screening) ratio of 80 percent or more for children ages 1-3.

The continuing evolution of EPSDT has spanned nearly four decades, with important modifications in 1972, and again in 1981, to add specific outreach and family support requirements to promote health care access. Amendments in 1989 further broadened medical assistance coverage to ensure full coverage for all physical, mental, and developmental conditions. Today EPSDT ensures coverage for all medically necessary diagnostic and treatment services that fall within the federal definition of "medical assistance" for virtually all Medicaid enrolled children. With very limited exceptions for "medically needy children," EPSDT is a service requirement for children who qualify for Medicaid on either a mandatory or optional basis. EPSDT can allow access to EPSDT to gain access to community-based and evidence-based services and therapies. Some of the aspects of high-value well-child care for young children considered best practice include age-appropriate mental health screening.

Some examples of best practices in other states are included in the following paragraphs. North Carolina pediatricians focused on improvements in developmental screening in clinical practice. In turn, these efforts resulted in a policy change with the state EPSDT (Health Check) requirements in 2004. One of the many components of a complete EPSDT visit is a developmental screening including mental, emotional, and behavioral. The new policy requires practices to use a formal, standardized developmental screening tool and encourages the use of the Current Procedural Terminology (CPT) code 96110-EP on the claim form.

Kansas' Medicaid program developed a web-based training for health care providers. Topics include requirements for developmental screening, recommendations for specific tools, and detailed information about billing and coding procedures related to developmental screening in primary care. These requirements were included in revised EPSDT guidelines.

Finally, more than half the states in the Assuring Better Child Health and Development (ABCD) collaborative found suggesting and recommending specific screening tools to be used during well child exams and testing them in pilot sites made a difference. For example, both Minnesota and Oregon developed comprehensive websites dedicated to promoting healthy development which included recommendations for specific tools. Other states have produced several iterations

of recommended tool lists, recognizing that different providers want varying levels of advice/instruction as they adopt improved standards of care.

### **Access to Dental Care**

Overall, our nation's oral health is good, but children in families with low incomes suffer disproportionately from dental caries, the infectious disease that causes cavities. While state Medicaid programs are required by federal law to provide dental services to eligible children, enrollees' access to dental care is poor. Dental caries can be prevented by a combination of community, professional, and individual measures including water fluoridation, professionally applied topical fluorides and dental sealants, and use of fluoride toothpastes.

Yet, tooth decay is the most common chronic disease of childhood. Dental care is the most prevalent unmet health need in US children with wide disparities existing in oral health and access to care. Only 1 in 5 children covered by Medicaid received preventive oral care for which they are eligible. Children from low income and minority families have poorer oral health outcomes, fewer dental visits, and fewer protective sealants.<sup>34</sup>

Since the great majority of dental care available in this country is delivered by private dentists, their participation is significant to improving access in Medicaid. Dentists cite three primary reasons for their low participation in state Medicaid programs: low reimbursement rates, burdensome administrative requirements, and problematic patient behaviors. In the late 1990s and early 2000s, a number of states took dramatic steps to improve access to dental care in Medicaid. Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington employed a variety of approaches to address access concerns: they raised reimbursement rates, revamped administrative structures and processes, and conducted outreach and education to both providers and patients.

Alabama established *Smile Alabama!* in October 2000, after a change in Medicaid leadership. The state raised reimbursement rates to 100 percent of the Blue Cross/Blue Shield dental fee schedule and improved the provider services rendered by its fiscal contractor. The state invested \$1 million of private funding in outreach activities, partnered with a dental advisory group, and collaborated with the dental association to improve access.

Michigan moved in 2000 to build upon a contract with a commercial dental insurer that had worked well in the state's SCHIP program to improve the Medicaid benefit for children in many of its non-urban counties. Under the Healthy Kids Dental program, most providers were reimbursed 100 percent of their usual charges. Enrollees gained access to the large pool of the insurer's participating dentists in their counties, and providers benefited from a program that used familiar administrative processes.

South Carolina began in 1998 with administrative improvements, and a provisional rate increase conditioned on an improvement in provider participation. Because the Medicaid agency, working

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<sup>34</sup> The Journal of the American Medical Association. 2012. See [<http://jama.jamanetwork.com/journal.aspx>]

closely with the state dental association, exceeded its provider enrollment target, reimbursement rates were raised to the 75th percentile of a commercially-available fee survey (meaning that Medicaid reimbursement rates were 75 percent or higher than the usual charges of dentists responding to the survey). The state also received private funding for outreach, especially to rural areas.

Washington created a model program called *Access to Baby and Child Dentistry (ABCD)* in 1995 to ensure that children ages 0-5 received services. The program provided case management for program enrollees and training for general dentists in caring for young children. In exchange for participating in ABCD, rates for certain procedures were raised to the 75th percentile of usual charges.

Tennessee “carved out” dental services from its TennCare medical managed care contracts in 2002, and contracted with Doral Dental, a specialized dental benefits manager. Reimbursement rates were increased to the 75th percentile of the 1999 ADA Survey of Fees for the East South Central region of states, and program administration was streamlined.

Virginia instituted its *Smiles for Children* program in 2005, which involved a statewide “carve out” contract very similar to Tennessee’s. Leadership at the state Medicaid agency and the state dental association worked closely to secure a 28 percent increase in reimbursement for all dental procedures, and target an additional 2 percent rate increase in 2006 to oral surgery procedures, which were identified as an area of acute need.

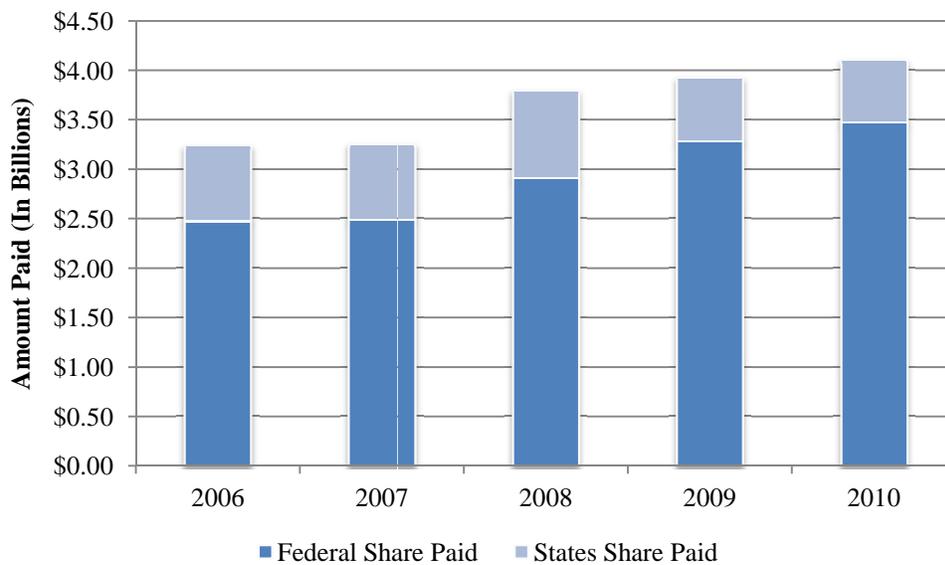
A study, sponsored by the California HealthCare Foundation, focuses on the efforts of these six states and compares their experiences to California’s. The National Academy for State Health Policy (NASHP) conducted a literature review and interviews with 26 key informants and found that rate increases are necessary – but not sufficient on their own – to improve access to dental care. Easing administrative processes and involving state dental societies and individual dentists as active partners in program improvement are also critical. Administrative streamlining and working closely with dentists can help maximize the benefit of smaller rate increases, and mitigate potential damage when state budgets contract.

In the six states examined, provider participation increased by at least one-third, and sometimes more than doubled, following rate increases. Not only did the number of enrolled providers rise, but so did the number of patients treated. Patients’ access to care, as measured by the number of enrollees using dental services, also increased after rates rose. Despite meaningful gains in provider participation and access achieved by these “front-runner” states, the portion of children receiving services is still far below the experience of privately-insured children. Data from 2004 show that 58 percent of privately insured children received dental services, while in these six states – after substantial effort and investment – 32 to 43 percent of children covered under Medicaid received dental care. The study concluded that the findings highlighted the need to explore other solutions as well.

## COST OF CURRENT SYSTEM

According to Kaiser Health Facts, Mississippi ranks 21<sup>st</sup> among states in the proportion of its budget spent on health care, largely due to the significant contribution of federal funding. However, in terms of State General Funds Mississippi spends significantly less when compared to the average for all states. Mississippi ranks as the fourth lowest in the nation in terms of the percentage of the state’s public health agency’s budget supported by State General Funds (Association of State and Territorial Health Officials). The following table displays the total Medicaid paid in Mississippi from 2006-2010.

**Graph 1. Total Medicaid Paid from 2006-2010<sup>35</sup>**



The table below provides detailed information on the enrollment and spending per enrollee over the past five years.

**Table 7. Medicaid Enrollments and Payments, MS, FY 2006-2010**

Year	Population	Enrollment Count	Total Medicaid Paid	Spending Per Enrollee
2006	2,897,150	787,955	\$3,239,823,118	\$4,112
2007	2,921,723	750,629	\$3,256,111,556	\$4,338
2008	2,940,212	736,867	\$3,793,448,781	\$5,148
2009	2,951,996	754,366	\$3,926,907,637	\$5,206
2010	2,960,467	772,166	\$4,106,064,588	\$5,318

<sup>35</sup> Medicaid.gov. “Mississippi Medicaid Statistics” 2012. See [<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/mississippi.html>]

In addition to the Medicaid and CHIP program budgets, Mississippi’s Department of Health also administers a combination of federal and state funds for health care services. The matrix below shows the breakdown amongst federal grants, entitlement funding, and general state funding for programs/services funded by the Health Department (These budget figures are specific to the Health Department’s Child and Adolescent Health Programs). *Please note, the information collected in this section is gathered from publicly available sources and does not provide a comprehensive breakdown of all programs that support the health and well-being of children in the early childhood population in the state.*

**Table 8. Mississippi Department of Health Program Funding FY 11-13**

Program	FY11	FY12	FY13
Early Intervention Federal Grant	\$4,389,623	\$4,372,987	\$4,409,878
Early Intervention State Gen Funds	\$1,454,656	\$1,353,008	\$1,363,717
NB Hearing/HRSA Grant	\$220,000	\$225,000	_____
NB Hearing/CDC Grant	\$150,000	\$138,246	\$138,246
Health Care Exp. Funds	\$221,954	\$221,954	\$221,954
NB Screening/Fees	\$4,000,000	\$4,083,065	\$4,088,387
*Title V MCH Block Grant	\$9,735,578	\$9,514,091	_____
Lead/CDC Grant	\$324,706	\$396,000	_____

\* Total award also includes Women's Health and Children/Youth with Special Health Care Needs

\*\* Funding includes Salaries, infrastructure/operations, and some direct services.

## RECOMMENDED ACTIONS

### **1. PCG recommends changes in Medicaid and CHIP eligibility determination process to include the removal of the face-to-face interview requirement.**

Too many young children in Mississippi have no health insurance coverage at all. Their lack of coverage restricts their access to health care services: uninsured children have fewer physician visits per year than children with insurance and are less likely to have a usual source of routine health care.<sup>36</sup> In recognition of the importance of health insurance for children's access to health care, a number of public programs, the largest of which is the federal-state Medicaid program, have been developed to provide health insurance benefits to poor children and others who would not otherwise have access to health care coverage. Mississippi should consider making these changes to its eligibility determination process for Medicaid and the Children's Health Insurance Program (CHIP).

First and foremost, Mississippi should eliminate the requirement for face-to-face interviews as part of the eligibility determination processes. This mechanism is clearly a barrier to health insurance coverage for young children (and others), and this fact is widely recognized by stakeholders throughout the state. Many parent(s) are not able to attend scheduled meetings, for reasons such as transportation, paperwork organization, job/work commitments, and child-care issues. It is recommended that the face-to-face requirement be removed from the initial eligibility determination process, but at the very least should be eliminated for eligibility renewals for continuing coverage for enrolled children. Mississippi stands alone in this anachronistic practice. All other states have **eliminated face-to-face interviews for children's Medicaid and CHIP renewals.**<sup>37</sup>

### **2. PCG recommends changes in Medicaid and CHIP eligibility determination process to include the implementation of "express lane eligibility".**

As an alternative to the face-to-face interview requirement, Mississippi can implement "express lane eligibility" (ELE) to utilize data from existing government databases and other means-tested programs to expedite and simplify eligibility determinations for Medicaid and CHIP. Express Lane Eligibility permits States to rely on findings, such as income, household size, or other factors of eligibility from another program designated as an ELA to facilitate enrollment in health coverage. In implementing ELE, Mississippi will need to determine whether to use this vehicle for just Medicaid or both Medicaid and CHIP. It is recommended that the state utilize the process for both programs to reach a larger share of uninsured children. Mississippi will also

<sup>36</sup> Newacheck, P.W., Hughes, D.C., and Cisternas, M. Children and health insurance: An overview of recent trends. *Health Affairs* (Spring 1995) 14,1:244–54; Monheit, A.C., and Cunningham, P.J. Children without health insurance. *The Future of Children* (Winter 1992) 2,2:154–70.

<sup>37</sup> Kaiser Family Foundation statehealthfacts.org. In Indiana, county offices may require telephone interviews, but not face-to-face interviews. The state began to allow for mail-in renewals without an interview in all but one county in 2011, with the last county scheduled to adopt this policy in the first quarter of 2012. Tennessee Medicaid requires a phone interview at renewal. See <http://www.statehealthfacts.org/comparetable.jsp?cat=4&ind=232>.

need to decide whether to use ELE for enrollment, renewal, or both activities. Again, utilizing the process for both will have the greatest impact on increasing access to health insurance coverage for young children. Of critical importance, Mississippi will need to determine ELAs from which to obtain eligibility findings and data and design a process to gather all necessary data and authorizations to determine eligibility. The state should consider a number of key factors in selecting ELAs, including: characteristics of the children served by the ELA, eligibility data available through the ELA, and whether the ELA offers favorable administrative conditions to support a cross-program effort. Some need-based programs provide access to most if not all of the eligibility findings and data that are needed to make a Medicaid or CHIP eligibility determination, while others may not. Ideally, the ELE process will minimize the need for additional steps to fill gaps in necessary information in order to complete the enrollment or renewal process in order to create, to the greatest extent possible, a single process that does not require families to submit a separate Medicaid/CHIP application.

**3. PCG recommends changes in Medicaid and CHIP eligibility determination process to include the implementation of presumptive eligibility.**

If any additional information is needed beyond that which can be provided by ELAs, Mississippi should also consider establishing presumptive eligibility as part of its ELE process. Presumptive eligibility is the process through which temporary health coverage is granted to a child while a final Medicaid or CHIP eligibility determination is being made. This involves extending coverage during a period of follow-up to obtain additional information and complete the eligibility determination. Presumptive eligibility provides young children with immediate access to coverage at the time they are seeking coverage and may be most likely to need it or use it. While presumptive eligibility benefits young children who appear to be eligible for Medicaid and CHIP by getting them coverage early, it is critically important to ensure these actually stay enrolled beyond their temporary eligibility period. For this reason, it is recommended that presumptive eligibility be implemented as part of the overall eligibility determination reforms discussed above.

**4. PCG recommends implementation of Family-Centered Medical Homes and leveraging enhanced Federal Financial Participation for Medicaid Health Homes under Section 2703 of the Affordable Care Act.**

Having a routine source of health care is one indicator of health access, continuity of services, and quality of care. While the ability to access health services has a significant impact on every aspect of the health, not enough young children in Mississippi have a regular primary care provider. The concept of a medical home has its origin in pediatric care. A medical home is, in essence a primary care provider who provides a regular, ongoing source of care. Among children with a routine source of care and continuity of care with one specific clinician is associated with better preventive care than not having a specific clinician, with having another source of sick care, or having no regular sick care source. When continuity of care is considered, having a good source of primary care is as important to preventive care as is insurance coverage. Mississippi

should implement medical-homes as a strategy to increase access to preventative care and other health services under the Medicaid EPSDT benefit.

Family-centered medical homes can provide the care young children need to stay healthy, identify any conditions that require further assessment or treatment, and provide families with information about what to expect as the child grows and how to support that growth. As a child's first and regular point of contact with the health care system, medical homes can improve linkages and feedback loops among the family, and other providers or programs that help children access the needed care for which they are eligible.

In addition to increasing access to services, there is strong evidence that a primary care-oriented health system may have benefits for population health, equity in health and cost containment, and reduce ethnic and racial health disparities.<sup>38</sup> Thus, medical homes can serve as an important strategy in promoting more equitable and cost-effective delivery of health services. Having and using a regular source of care has a powerful influence in reducing hospitalizations, especially for conditions for which continuity of care is especially effective in reducing the need to be hospitalized. Improved collaborations between primary care providers and local hospitals can significantly increase Medicaid beneficiaries' use of regular sources of care and therefore reduce inappropriate ER use substantially.<sup>39</sup>

Mississippi may be able to leverage additional Federal Financial Participation (FFP) to assist in implementing a family-centered medical home initiative. Section 2703 of the Affordable Care Act (ACA) created a Medicaid State Plan Option for "health home services" for Medicaid beneficiaries with chronic conditions. To be eligible for a Health Home, an individual must have at least two chronic conditions, one chronic condition and be at risk for another or one serious and persistent mental health condition. Chronic conditions identified in statute include mental health, substance use disorder, asthma, diabetes, heart disease, and being overweight (as evidenced by a BMI of >25). States may also request that CMS identify other chronic conditions for purposes of eligibility. Given the prevalence of asthma and obesity in Mississippi's child population, these two conditions should receive special consideration. Mississippi's childhood obesity rates are the highest in the nation.<sup>40</sup> Child lifetime asthma prevalence and child current asthma prevalence are higher than 38 other states' rates and the prevalence of current asthma is twice as high in black children compared to white children.<sup>41</sup>

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<sup>38</sup> A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey, (New York, NY: The Commonwealth Fund, June 2007). Retrieved January 8, 2010.

<http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Closing-the-Divide--How-Medical-Homes-Promote-Equity-in-Health-Care--Results-From-The-Commonwealth-F.aspx>.

<sup>39</sup> R. Rosenblatt, "The Canary in the Mine: Emergency Room Overcrowding and the U.S. Health Care System," presentation to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), December 2003.

<sup>40</sup> Centers for Disease Control and Prevention. "Adolescent and School Health- Obese Youth Over Time" 2012. See [<http://www.cdc.gov/healthyyouth/obesity/obesity-youth-txt.htm>]

<sup>41</sup> Source: Center for Disease Control and Mississippi Behavioral Risk Factor Surveillance System, 2009. see [http://www.cdc.gov/asthma/stateprofiles/Asthma\\_in\\_MS.pdf](http://www.cdc.gov/asthma/stateprofiles/Asthma_in_MS.pdf).

If Mississippi creates health homes under the authority of section 2703 of the ACA, it will receive two years of enhanced federal financial participation (FFP) for health home services. Rather than the state's typical Medicaid match rate, Mississippi with approved health home plans will receive 90% FFP for health home services for the first two years (i.e. eight quarters) the Medicaid State Plan option is in effect. This enhanced FFP can help to offset implementation costs. Going forward, Mississippi should establish mechanisms, and embed such requirements in Medicaid provider agreements and health plan contracts, to hold providers accountable for important outcomes that increase access to preventative care and lessen the need for more costly acute care services (e.g. inpatient care and emergency room use). Establishing a clear return on investment (ROI) for this new service delivery model will demonstrate the sustainability of a family-centered medical home initiative where long-term costs are offset by corresponding health care savings.

**5. PCG recommends Medicaid contract with dental managed care organization or administrative service organization to improve access to covered dental services.**

The scarcity of pediatric dental specialists and limited participation of these dentists in the Medicaid program – who account for less than 37 percent of all participating dentists – are widely recognized barriers in access for children in Mississippi. Several states have looked to specialized dental managed care entities to address such barriers. Through the contracting approach, Mississippi should be able to increase access to dental care by paying enhanced rates for services to enrolled children, recruiting more private dentists to care for them, and training those dentists in techniques for managing young children. Medicaid dental managed care contractors could also be used to pay for innovative programs, such coverage for items (e.g. toothbrushes, toothpaste, and floss) not ordinarily paid for by Medicaid. To finance this, Mississippi could leverage the experience of the administering entity to rebalance funding for covered dental services – for example, employing evidenced-based guidelines to tighten criteria for coverage of orthodontic services.

**APPENDIX A.**

**State-to-state Comparison of Demographics and Health Care Indicators<sup>42</sup>**

<b>STATE</b>	<b>MS</b>	<b>AR</b>	<b>IL</b>	<b>NC</b>	<b>OK</b>	<b>OR</b>	<b>LA</b>	<b>WA</b>
<b>POPULATION/DEMOGRAPHICS</b>								
Population Number (millions), 2009	3	2.9	12.9	9.4	3.7	3.8	4.5	6.7
Population, 2009, Rank	31	32	5	10	28	27	25	13
Population Ages 0-4 Years , 2010 Estimate, Percent	0.071	0.068	0.072	0.069	0.071	0.066	0.073	0.065
Population, White, July 2008, Percent	0.606	0.808	0.791	0.739	0.781	0.901	0.648	0.843
Population, Black or African American, July 2008, Rank	1	13	14	7	24	41	2	
Population, Black or African American, July 2008, Percent	0.372	0.158	0.149	0.216	0.08	0.02	0.32	0.037
Population, Hispanic, July 2008, Percent	0.022	0.056	0.152	0.074	0.076	0.11	0.034	0.098
<b>POVERTY</b>								
Persons Below Poverty Level, 2008, Rank	1	2	27	15	7	17	2	33
Persons Below Poverty Level, 2008, Percent	0.218	0.173	0.122	0.146	0.159	0.136	0.173	0.113
Low Income Children Under Age 6	0.57	0.59	0.28	0.51	0.53	0.47	0.48	0.4
Rural Population, 2000, Percent	0.512	0.475	0.122	0.398	0.347	0.213	0.274	0.18
Population Density/Inhabitants per Square Mile, 2010	63.2	56	231.1	196.1	54.7	39.9	104.9	101.2
<b>BIRTH AND OUTCOME DATA</b>								
Birth Rate, 2009	14.5	13.8	13.3	13.5	14.8	12.3	14.5	13.4
Birth Rates for Teenagers 15-19 years, 2009	64.2	59.2	36.1	44.9	60.1	33.1	52.7	31.9
Preterm Births, 2009, Percent	0.18	0.131	0.124	0.13	0.138	0.098	0.147	0.103
Low Birth weight Births, 2009, Percent	0.122	0.089	0.084	0.09	0.084	0.063	0.106	0.059

<sup>42</sup> Information found on individual state early childhood state plans, advisory council updates and/or annual reports, and Race to the Top- Early Learning Challenge Grant application sections on the current early childhood delivery system in the state

STATE	MS	AR	IL	NC	OK	OR	LA	WA
<b>BIRTH AND OUTCOME DATA</b>								
Infant Mortality Rate, 2006	10.6	8.5	7.3	8.1	8	5.5	9.9	4.7
Medicaid Births, 2009, Percent of Total Births	NA	0.64	NA	0.51	0.64	0.43	NA	
<b>HEALTH CARE ACCESS INDICATORS</b>								
Doctors per 1,000 Residents, 2007	177.9	203.4	280.2	254.2	173.5	274.5	262.7	270
Children Uninsured, 2009, Percent	0.109	0.115	0.091	0.118	0.126	0.119	0.084	0.048
Young Children Who Lack Insurance Coverage, 2009, Percent	0.17	0.15	0.09	0.14	0.17	0.17	0.15	0.12
Medicaid Enrolled Low Income Children, 2009, % of All Insured	0.682	0.651	0.645	0.6	0.636	0.535	0.716	0.676
Medicaid Participation Rate, 2009, Percent	0.854	0.928	90.8	0.878	0.845	0.825	0.895	0.859
Low Income Children w/ Medical Home (Public Ins), 2007, Percent	0.74	0.69	0.67	0.68	0.74	0.48	0.81	0.75
Medicaid Spending Per Child, 2009	1961	1946	2295	2528	2214	2143	1672	1982
Eligible Children (<1) w/ At Least One EPSDT Visit, 2008, Percent	0.77	0.57	0.85	0.93	0.89	0.84	0.9	0.78
Eligible Children (1-2) w/ At Least One EPSDT Visit, 2008, Percent	0.6	0.5	0.75	0.88	0.6	0.7	0.77	0.83
Eligible Children (3-5) w/ At Least One EPSDT Visit, 2008, Percent	0.49	0.67	0.64	0.59	0.45	0.56	0.62	0.53
Head Start Spending Per Child, 2009	6304	6341	7099	7727	6219	5546	7073	9201
Birth thru 2 Receiving EIS Under Part C, 2008, % of Population	0.015 6	0.023 3	0.028 6	0.023 3	0.017 9	0.017 4	0.020 3	0.018 6
<b>EARLY CHILDHOOD PRIORITY/FOCUS AREAS</b>								
Prenatal and Child Health	✓	✓		✓			✓	
Increased Access to Programs	✓	✓	✓	✓	✓	✓		✓
Coordination Across Programs	✓	✓	✓	✓	✓	✓	✓	✓
Mental Health/Social-Emotional Development		✓		✓			✓	

STATE	MS	AR	IL	NC	OK	OR	LA	WA
Children with Special Needs		✓					✓	
Data System Development	✓	✓	✓	✓	✓	✓	✓	✓

**APPENDIX B.**

**State’s CHIPRA Bonus from FY2009-FY2011<sup>43</sup>**

	State Received FY2011 CHIPRA Bonus	FY2011 Bonus	State Received FY2010 CHIPRA Bonus	FY2010 Bonus	State Received FY2009 CHIPRA Bonus	FY2009 Bonus
United States	Yes	\$296,450,906	Yes	\$206,157,744	Yes	\$75,372,375
Alabama	Yes	\$19,758,656	Yes	\$54,965,407	Yes	\$39,752,546
Alaska	Yes	\$5,660,544	Yes	\$4,408,789	Yes	\$707,253
Arizona	No	NA	No	NA	No	NA
Arkansas	No	NA	No	NA	No	NA
California	No	NA	No	NA	No	NA
Colorado	Yes	\$26,141,052	Yes	\$13,671,043	No	NA
Connecticut	Yes	\$5,209,262	No	NA	No	NA
Delaware	No	NA	No	NA	No	NA
District of Columbia	No	NA	No	NA	No	NA
Florida	No	NA	No	NA	No	NA
Georgia	Yes	\$4,965,887	No	NA	No	NA
Hawaii	No	NA	No	NA	No	NA
Idaho	Yes	\$1,302,552	No	NA	No	NA
Illinois	Yes	\$15,069,869	Yes	\$14,962,171	Yes	\$9,460,312
Indiana	No	NA	No	NA	No	NA
Iowa	Yes	\$9,575,525	Yes	\$6,760,901	No	NA
Kansas	Yes	\$5,862,957	Yes	\$2,578,099	Yes	\$1,220,479
Kentucky	No	NA	No	NA	No	NA
Louisiana	Yes	\$1,929,692	Yes	\$3,555,853	Yes	\$1,548,387
Maine	No	NA	No	NA	No	NA
Maryland	Yes	\$28,301,384	Yes	\$10,549,086	No	NA
Massachusetts	No	NA	No	NA	No	NA
Michigan	Yes	\$5,902,731	Yes	\$9,268,552	Yes	\$4,721,855
Minnesota	No	NA	No	NA	No	NA
Mississippi	No	NA	No	NA	No	NA

<sup>43</sup> State Health Facts, The Henry J. Kaiser Family Foundation. “Medicaid and CHIP” State Facts. See <http://www.statehealthfacts.org/index.jsp> 10 July 2012.

	State Received FY2011 CHIPRA Bonus	FY2011 Bonus	State Received FY2010 CHIPRA Bonus	FY2010 Bonus	State Received FY2009 CHIPRA Bonus	FY2009 Bonus
Missouri	No	NA	No	NA	No	NA
Montana	Yes	\$6,473,416	No	NA	No	NA
Nebraska	No	NA	No	NA	No	NA
Nevada	No	NA	No	NA	No	NA
New Hampshire	No	NA	No	NA	No	NA
New Jersey	Yes	\$16,822,537	Yes	\$8,788,959	Yes	\$3,131,195
New Mexico	Yes	\$4,971,028	Yes	\$8,533,431	Yes	\$5,365,601
New York	No	NA	No	NA	No	NA
North Carolina	Yes	\$21,135,087	No	NA	No	NA
North Dakota	Yes	\$3,195,768	No	NA	No	NA
Ohio	Yes	\$21,036,616	Yes	\$12,376,346	No	NA
Oklahoma	No	NA	No	NA	No	NA
Oregon	Yes	\$22,493,771	Yes	\$15,055,255	Yes	\$1,603,336
Pennsylvania	No	NA	No	NA	No	NA
Rhode Island	No	NA	No	NA	No	NA
South Carolina	Yes	\$2,383,837	No	NA	No	NA
South Dakota	No	NA	No	NA	No	NA
Tennessee	No	NA	No	NA	No	NA
Texas	No	NA	No	NA	No	NA
Utah	No	NA	No	NA	No	NA
Vermont	No	NA	No	NA	No	NA
Virginia	Yes	\$26,729,489	No	NA	No	NA
Washington	Yes	\$16,987,468	Yes	\$17,607,725	Yes	\$7,861,411
West Virginia	No	NA	No	NA	No	NA
Wisconsin	Yes	\$24,541,778	Yes	\$23,076,127	No	NA
Wyoming	No	NA	No	NA	No	NA