AN ACT TO AMEND SECTIONS 41-86-5, 41-86-13, 41-86-15 AND
41-86-17, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT PREGNANCY
RELATED ASSISTANCE FOR TARGETED LOW-INCOME PREGNANT WOMEN AND
NEWBORNS SHALL BE ELIGIBLE FOR REIMBURSEMENT UNDER THE MISSISSIPPI
CHILDREN'S HEALTH CARE ACT (CHIPS) IN ACCORDANCE WITH THE
PROVISIONS OF THE FEDERAL "MOTHERS AND NEWBORNS HEALTH INSURANCE
ACT OF 2001"; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. Section 41-86-5, Mississippi Code of 1972, is
amended as follows:

41-86-5. As used in Sections 41-86-5 through 41-86-17, the
following definitions shall have the meanings ascribed in this
section, unless the context indicates otherwise:

(a) "Act" means the Mississippi Children's Health Care
Act.

(b) "Administering agency" means the agency designated
by the Mississippi Children's Health Insurance Program Commission

(c) "Board" means the State and Public School Employees
Health Insurance Management Board created under Section 25-15-303.

(d) "Child" means an individual who is under nineteen
(19) years of age who is not eligible for Medicaid benefits and is
not covered by other health insurance.

(e) "Commission" means the Mississippi Children's
Health Insurance Program Commission created by Section 41-86-7.

(f) "Covered benefits" means the types of health care
benefits and services provided to eligible recipients
under the Children's Health Care Program.
(g) "Division" means the Division of Medicaid in the Office of the Governor.

(h) "Low-income child" means a child whose family income does not exceed two hundred percent (200%) of the poverty level for a family of the size involved.

(i) "Low-income pregnant woman" has the meaning given the term "low-income child" as if any reference to a child were deemed a reference to a woman during pregnancy and through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends.

(j) "Plan" means the State Child Health Plan.

(k) "Program" means the Children's Health Care Program established by Sections 41-86-5 through 41-86-17.

(l) "Recipient" means a person who is eligible for assistance under the program.

(m) "State Child Health Plan" means the permanent plan that sets forth the manner and means by which the State of Mississippi will provide health care assistance to eligible uninsured, low-income children consistent with the provisions of Title XXI of the federal Social Security Act, as amended.

SECTION 2. Section 41-86-13, Mississippi Code of 1972, is amended as follows:

41-86-13. (1) The Division of Medicaid shall receive state appropriations for the program and federal matching funds under the State Children's Health Insurance Program established by Title XXI of the federal Social Security Act, as amended by the federal Mothers and Newborns Health Insurance Act of 2001, and the division shall provide those funds to the administering agency for the administration of the program. The Legislature shall include those funds as a line item in the appropriation to the Division of Medicaid.

(2) The program is subject to the availability of state funds specifically appropriated by the Legislature for the purpose
of the program and federal matching funds under the State Children's Health Insurance Program established by Title XXI of the federal Social Security Act, as amended by the federal Mothers and Newborns Health Insurance Act of 2001. The division may limit enrollment as necessary to ensure that the costs of the program do not exceed the total amount of state and federal funds appropriated by the Legislature for that purpose.

SECTION 3. Section 41-86-15, Mississippi Code of 1972, is amended as follows:

41-86-15. (1) Persons eligible to receive covered benefits under Sections 41-86-5 through 41-86-17 shall be low-income children who meet the eligibility standards set forth in the plan. Any person who is eligible for benefits under the Mississippi Medicaid Law, Section 43-13-101 et seq., shall not be eligible to receive benefits under Sections 41-86-5 through 41-86-17. A person who is without insurance coverage at the time of application for the program and who meets the other eligibility criteria in the plan shall be eligible to receive covered benefits under the program, if federal approval is obtained to allow eligibility with no waiting period of being without insurance coverage. If federal approval is not obtained for the preceding provision, the Division of Medicaid shall seek federal approval to allow eligibility after the shortest waiting period of being without insurance coverage for which approval can be obtained. After federal approval is obtained to allow eligibility after a certain waiting period of being without insurance coverage, a person who has been without insurance coverage for the approved waiting period and who meets the other eligibility criteria in the plan shall be eligible to receive covered benefits under the program. If the plan includes any waiting period of being without insurance coverage before eligibility, the State and School Employees Health Insurance Management Board shall adopt regulations to provide exceptions to the waiting period for
families who have lost insurance coverage for good cause or through no fault of their own.

(2) The eligibility of children for covered benefits under the program shall be determined annually by the same agency or entity that determines eligibility under Section 43-13-115(9) and shall cover twelve (12) continuous months under the program.

(3) There will be presumptive eligibility under this chapter for children under nineteen (19) years of age, in accordance with the following provisions:

(a) A child will be deemed to be presumptively eligible for covered benefits and services under this chapter if a qualified entity as defined under federal law (42 USCS Section 1396r-1a) determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the plan.

(b) A child will be presumptively eligible under this chapter from the date that the qualified entity determines that the child is presumptively eligible until the earlier of either:

(i) The date on which a determination is made with respect to the eligibility of the child for covered benefits and services under this chapter, or

(ii) The last day of the month following the month in which presumptive eligibility is determined, if an application has not been filed on behalf of the child by that day.

(c) For the period during which a child is presumptively eligible under this chapter, the child will be eligible to receive all covered benefits and services under this chapter.

(d) If a child is determined to be presumptively eligible under this chapter, the child's parent, guardian or caretaker relative must submit a completed application for assistance under the program no later than the last day of the month following the month in which presumptive eligibility is
determined. The qualified entity shall inform the parent, guardian or caretaker relative of this requirement at the time the qualified entity makes the determination of presumptive eligibility.

(e) The qualified entity shall notify the Division of Medicaid of the determination of presumptive eligibility within five (5) working days after the date on which the determination is made.

(f) The Division of Medicaid shall provide qualified entities with such forms as are necessary for an application to be made on behalf of a child for eligibility under this chapter. The Division of Medicaid shall make those application forms and the application process itself as simple as possible.

(4) The eligibility of low-income pregnant women for pregnancy-related assistance under the program shall be determined by the same agency or entity that determines eligibility under Section 43-13-115(9). There shall be no exclusion of benefits for services described in Section 41-86-17 based on any pre-existing condition, and no waiting period shall apply. If a child is born to a low-income pregnant woman who was receiving pregnancy-related assistance under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the child health program on the date of such birth, to have been found eligible for such assistance under such program, and to remain eligible for such assistance until the child attains one (1) year of age, so long as the child is a member of the woman's household. The commission shall establish a procedure under which local and community based public or nonprofit private organizations, local and county governments, public health departments, community health centers, children's hospitals, and disproportionate share hospitals may seek to have administrative costs relating to outreach and enrollment of
children and pregnant women under this program treated as administrative costs of the state on a reimbursable basis.

SECTION 4. Section 41-86-17, Mississippi Code of 1972, is amended as follows:

41-86-17. The covered benefits under the program shall include all health care benefits and services required to be included as covered benefits under Title XXI of the federal Social Security Act, as amended, and shall include early and periodic screening and diagnosis services at least equal to those provided under the Medicaid program. The benefits and services offered and available to state employees under the State and School Employees Health Insurance Plan shall be used as the benchmark for benefits and services under the program, with an emphasis on preventive and primary care. Benefits and services to be provided under the program shall include: vision and hearing screening, eyeglasses and hearing aids, preventive dental care and routine dental fillings. No deductibles, coinsurance or any other cost-sharing shall be allowed for any of the benefits and services named in the preceding sentence. The program also may cover other dental services including amalgam and composite restorations, extractions, space maintainers, stainless steel crowns, sealants, pulpotomies, pulpectomies, and treatment of periodontal disease. The program may exclude from participation in the program any health care providers who do not agree to hold the families of recipients harmless for charges in excess of plan payments for covered benefits. From and after July 1, 2002, benefits shall also include pregnancy-related assistance in accordance with the provisions of the federal Mothers and Newborns Health Insurance Act, which shall include prenatal, delivery, postpartum services and other conditions that may complicate pregnancy, but shall not include pre-pregnancy services and supplies.

SECTION 5. This act shall take effect and be in force from and after July 1, 2002.