

Transmittal Letter for Annual report

December 31, 2000

Jennifer Ryan
Health Care Financing Administration
7500 Security Boulevard
Mail Stop: S2-01-13
Baltimore, MD 21244

Dear Ms. Ryan:

Enclosed is a copy of Kentucky's Annual Report of the State Children's Health Insurance Program for Federal Fiscal Year 2000. The annual report framework was used to formulate the report. The annual data report was submitted to HCFA earlier in December.

Kentucky continues to work hard to implement the children's health insurance program, and we value the support to provide improved access to health care to Kentucky's children.

Sincerely,

Dennis Boyd
Commissioner

Enclosure

Three copies need to be sent to Andriette Johnson; HCFA – Atlanta; 61 Forsyth St. SW, Suite 4T20; Atlanta, GA 30303-8909

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

Preamble

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

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

The framework is designed to:

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

Submission Date **December 22, 2000**

12/27/00

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

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

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

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

1. Program eligibility NC
2. Enrollment process **Self-declaration of income became effective July 1, 2000.**
3. Presumptive eligibility **Presumptive eligibility is not an option at this time. It was determined that other new policy and procedures negated its benefits; i.e., use of two page mail-in application, self-declaration of income, 90 day retroactive enrollment and average length of time from receipt of application to enrollment.**
4. Continuous eligibility NC
5. Outreach/marketing campaigns **Extensive media campaign including TV, radio and print; local outreach through public health; speaker's bureau; employers kit; Kentucky Farm Workers Campaign; door-to-door campaign in the spring; partnership with McDonalds and Walmart for spring campaign; state fair campaign; and back-to-school campaign.**
6. Eligibility determination process **Expanded use of the two page, mail-in application has significantly reduced the number of face-to-face interviews, and the use of self-declaration of income and disabled adult and child care expenses have also shortened the eligibility determination process. In an effort to maintain a low error rate, workers do verify the statement if there is reason to doubt the information provided.**
7. Eligibility redetermination process **Eligibility redetermination is required every twelve months, and the process has been changed by having the recipient receive pre-printed information through the mail which must be verified, signed and returned within a prescribed time frame.**
8. Benefit structure **The benefit structure for Kentucky's separate insurance program for children in families from 150% to 200% FPL is the same as Medicaid, except EPSDT Special Services and non-emergency transportation are not covered.**

9. Cost-sharing policies **No cost sharing (premiums or co-pays) is required.**
10. Crowd-out policies **NC**
11. Delivery system **The service delivery mechanism for Kentucky's separate insurance program for children in families from 150% to 200% FPL has been changed from Accountable Pediatric Organizations to Kentucky's Department for Medicaid Services delivery system.**
12. Coordination with other programs (especially private insurance and Medicaid) **Eligibility and health care services for Kentucky's separate insurance program are provided through the existing Medicaid service delivery system.**
13. Screen and enroll process **NC**
14. Application **NC**
15. Other

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

Cumulative enrollment for FFY 2000 began at 22,736 in October 1999 and grew to 62,110 by the end of September, 2000. A chart with cumulative enrollment by each of the KCHIP phases is included in the appendix.

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

Please see the chart in the appendix for the number of uninsured children enrolled in KCHIP through the end of FFY 2000.

The Kentucky Legislative Research Commission (LRC) conducts an annual survey of the uninsured. In 1997, it was estimated that 15.2% of the children under 19 were uninsured in Kentucky. In 1998, the estimate was 13.5%, and in 1999, it was 9.9%. The 1999 data was the first year to reflect KCHIP implementation.

The LRC has studied the insurance status of the state since 1996. Data is collected through annual telephone surveys and combined with data from the March Supplement

to the annual Current Population Survey.

Because the sample size of children is fairly small for any one year, data for 1997-1999 were combined to increase the sample size. The advantage is that it is possible to look at very narrowly defined segments of the child population, which is necessary when estimating the number of children eligible for KCHIP. The disadvantage of combining multiple years of data is that it is not possible to track changes over time.

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

Kentucky uses a joint application and eligibility determination process, and in June, 1999, an extensive and aggressive outreach campaign was initiated that included the use of a two-page, mail-in application. It is estimated that Medicaid enrollment increased by approximately 11% as a result of KCHIP outreach activities and enrollment simplification.

There were 242,247 children enrolled in Medicaid in July, 1999, and one year later in June, 2000, there were 271,332 children enrolled in Medicaid which is an increase of 29,085 or 11%. Also, comparing the quarterly enrollments during FFY99 to FFY00 shows a steady increase. The increase in the first quarter was 2.25%, in the second quarter it was 5.4%, in the third quarter it was 1%, and in the fourth quarter it was 1.1%. A copy of the comparison chart is included in the appendices.

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

A Legislative Research Commission memo titled the “Rate of Uninsured Children Declines” is included in the appendices.

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

 X No, skip to 1.3

 Yes, what is the new baseline?

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

What was the justification for adopting a different methodology?

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

available.)

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

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

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

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

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

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Within two years increase numbers of children with creditable coverage	<ul style="list-style-type: none"> KCHIP separate insurance program will achieve 50% penetration and enroll 10,000 children. The Medicaid expansion will enroll approximately 27,500 additional children. 	Data Sources: <ul style="list-style-type: none"> Medicaid and KCHIP enrollment data KY Legislation Research Commission (LRC) annual insurance studies. Methodology: <ul style="list-style-type: none"> The LRC study uses calculated averages from a 3 year average of the most recent March supplement to the CPS produced by the Bureau of Census and augmented by the LRC household survey. Progress Summary: <ul style="list-style-type: none"> KCHIP has achieved and exceeded the performance goal. As of September 30, 2000, a total of 62,110 children had been enrolled in the three phases of KCHIP from the beginning of the program on July 1, 1998. On September 30, 2000, there were 13,193 children enrolled in the separate insurance program. On September 30, 2000, there were 34,920 children enrolled in the Medicaid expansion.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
<p>Within five years increase health status of children.</p>	<ul style="list-style-type: none"> • 90% of children covered under KCHIP will have complete immunization by age 3, • 95% of 13 year olds in KCHIP will have complete immunizations, • 75% of children under 18 months of age will receive the recommended number of well child visits, • 75% of children between 3 and 6 years of age will receive at least one well child exam, • 75% of children 12-17 will receive at least one well child exam annually, • 75% of children will receive routine vision screening yearly by PCP, 	<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p> <ul style="list-style-type: none"> • KCHIP data will be reported in FFY 2003. KCHIP will work with the Department for Medicaid Services and Passport Health Plan to establish baseline data. • Baseline data on well-child visits in the first 15 months of life for all children enrolled in Medicaid during SFY 97 have been established. <i>(Attachment in appendices)</i> • Passport Health Plan, which is the only managed care organization providing services to children enrolled in KY Medicaid and KCHIP, has measured HEDIS results for well-child visits in the first 15 months of life, well-child visits in the 3rd, 4th, 5th and 6th year of life, adolescent well-care visits, and childhood and adolescent immunizations. Passport Health Plan is collecting HEDIS data to become certified by NCQA. <i>(Attachment in appendices)</i> • The HCFA 416 Annual EPSDT Participation Report for FFY 1999 shows that 39% of the total eligible children received at least one initial or periodic Screen.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	<ul style="list-style-type: none"> 75% of children will receive an eye exam by an eye care specialist between age 3-6. 	
OTHER OBJECTIVES		
<ol style="list-style-type: none"> Within two years reduce barriers to affordable health coverage Within one year of HCFA plan approval, provide statewide coverage 	<ul style="list-style-type: none"> Cost sharing will be at a level that families will enroll in KCHIP with at least 30,000 participants. Provide statewide coverage with KCHIP through a contract or the state run Medicaid program. 	<p>Data Sources:</p> <ol style="list-style-type: none"> Not applicable at this time. KCHIP Annual Report for FFY98 to HCFA <p>Progress Summary:</p> <ol style="list-style-type: none"> Cost sharing has not been implemented. KCHIP separate insurance program has changed the service delivery mechanism by removing Accountable Pediatric Organizations and substituting the existing Medicaid infrastructure. KCHIP was fully implemented statewide on November 1, 1999. This performance goal was met within the targeted time frame.

- 1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.
- 1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.
- 1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The length of time to measure the strategic objective addressing use of preventive care has been changed from three to five years. The primary reason for changing is based on the current change in the service delivery mechanism to be used by the Kentucky Department for Medicaid Services. During the next fiscal year, baselines will be established for performance goals. Please find attached baselines for Region 3, which is the only operating managed care organization utilized by Medicaid in the State, for well child visits and immunizations. There is also a chart prepared by the Department for Medicaid Services on well child visits in the first 15 months of life by Region, and data on statewide EPSDT Screening by age group for FFY 1999 is also reported on the HCFA 416.

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

SECTION 2. AREAS OF SPECIAL INTEREST

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

2.1 Family coverage: NA

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

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

Number of adults _____

Number of children _____

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

2.2 Employer-sponsored insurance buy-in: NA

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

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

Number of adults _____

Number of children _____

2.3 Crowd-out:

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

A child is ineligible for the KCHIP Medicaid expansion or separate insurance program for targeted low income children if they have had private insurance coverage in the six months prior to the application. An application may be approved in cases where coverage ended less than six months prior to determination of eligibility if coverage was terminated for reasons beyond the parent's control, such as: 1) Loss of employment; 2) death of a parent; 3) divorce, where children's coverage had been provided by a non-parental adult; 4) change of employment; 5) change of address so that no employer-sponsored coverage is available; 6) discontinuation of health benefits

to all employees of the applicants employer; 7) expiration of COBRA; 8) self employment; and 9) termination of health benefits due to a long term disability.

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

Eligibility determination workers code denied applications by reason for denial which includes that the child has insurance or has had insurance within the past six months. A monthly report is sent to KCHIP for review and analysis.

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

Denial codes were monitored for seven months during FFY 2000. There were more than 5750 applications denied during that time, and 54% of the denials were because the applicant failed to supply all the required information and documentation. The second (16%) most frequent denial of an application is because the applicant is currently receiving Medicaid, the third (14%) reason for denial is that the applicant is over income limits, and the fourth (9%) most frequent denial is because the applicant has insurance. To provide more specific information on crowd-out, a quality control evaluation project will be conducted during FFY 2001.

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

2.4 Outreach:

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

The top three most effective approaches have been: brochures/flyers; promotional items; and signs/posters. The three most effective strategies or "best practices" for enrolling children were: involving the schools; advertising, including TV spots, PSAs and newspaper ads; and door-to-door efforts and involving the local health departments.

- B. How have you measured effectiveness?

There were four methods used to measure outreach effectiveness. There were; 1) a survey was conducted targeting outreach workers ; 2) eight focus groups were held statewide targeting potentially eligible families; 3) three focus groups were held involving policy leaders, advocates, and agency leaders; and 4) a two day strategic planning conference

involving more than 50 participants.

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

A contract was initiated with the UK Farm Workers Program to target Latino and Hispanic populations. The contract provided translation services and door-to-door outreach in 11 counties. There were over 400 applications distributed, over 300 phone calls made, 75 face-to-face contacts made, and 230 door-to-door outreach contacts made.

The most current available data by race was used to measure effectiveness. There were .8% of the Kentucky population classified as Hispanic, and KCHIP data in September, 2000 indicated that .9% of the enrolled children in KCHIP were Hispanic. Using this indicator as a guide, it is considered that outreach efforts targeting Kentucky's Hispanic speaking population have been effective.

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

Specific data are not available.

2.5 Retention:

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

Face to face interviews are no longer required. Pre-printed forms are mailed to families with children who need to recertify in the month prior to recertification, and the parent or legal guardian is required to verify the information, sign and return it. The disenrollment rate is approximately 3%. A disenrollment survey will be conducted in January 2001.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

Follow-up by caseworkers/outreach workers

Renewal reminder notices to all families

Targeted mailing to selected populations, specify population _____

Information campaigns

Simplification of re-enrollment process, please describe: **Pre-printed forms mailed to enrolled children, self declaration of income accepted.**

Surveys or focus groups with disenrollees to learn more about reasons for disenrollment,

please describe: A random sample, mailed survey will be conducted in January, 2001 of KCHIP disenrollees to determine reasons children do not re-enroll, where health care will be accessed in the future and method of payment.

___ Other, please explain _____

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

Yes; however Medicaid is not conducting a survey of disenrollees.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?
5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

2.6 Coordination between SCHIP and Medicaid:

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

Yes, all procedures are the same.

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

This has been programmed into the automated eligibility system. The eligibility determination workers enter status changes into the system that effect eligibility, and if a change results in a child transferring to a different program, a member card reflecting the correct status is mailed to the enrolled child at the end of the month. A new member card is mailed each month whether there is a status change or not.

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

Cost Sharing:

Kentucky has not implemented cost sharing.

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

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

Assessment and Monitoring of Quality of Care :

Kentucky will be developing baselines for performance goals this year in cooperation with Medicaid.

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.
2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?
3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

SECTION 3. SUCCESSES AND BARRIERS

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

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas.

Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

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

1. Eligibility

Successes On November 1, 1999, the separate insurance program of Kentucky's plan was implemented statewide. This phase of KCHIP, Phase III, expanded eligibility up to 200% FPL.

Barriers There are two issues that can be categorized as barriers, and these two issues are difficult for potentially eligible families to understand; i.e., federal policy related to the public charge issue and the six month waiting period without voluntarily dropping health insurance to control for crowd out. Eligibility workers and hot line staff have received training and explanatory memos to help them more fully understand these issues. Also, when meetings with workers have been held, these issues have been discussed. The approach taken was to provide the front-line worker with accurate and current information who in turn could explain it to the families.

2. Outreach

Successes One key to our success is the on-going communication and support to the network of community partners. A newsletter is distributed periodically, and a planning conference was held in the Spring involving 50 partners to provide the basis for a three year outreach plan. A second key to success was the on-going, comprehensive media campaign that was conducted through June, 2000. Finally, the contract with Kentucky's Farm Worker Program has provided door-to-door outreach to thirteen counties with the highest percentage of Latino or Hispanic families.

Barriers Two barriers have been identified and addressed. One is to target more funding to support efforts to contact the hard-to-reach families with eligible children, and the other is to develop an outreach campaign for providers who can recommend that families enroll in KCHIP.

3. Enrollment

Successes Enrollment performance goals have been achieved and exceeded, and monthly enrollment continues to climb at a steady pace. Two enrollment campaigns that

have been successful for the past two years have been the Back-to-School campaign and outreach efforts through the State Fair. The Back-to-School campaign's success is the result of early and thorough planning, support, and cooperation of the Covering Kids Grant, the State Department of Education, the Family Resources and Youth Services Centers, the Department for Medicaid Services and the local schools.

Barriers The most significant barrier to enrollment that has been encountered is the welfare stigma associated with the program. The approach has been to provide more information about KCHIP, explain why and how it works, and inform the public and providers that it is for *working* families whose children are uninsured.

4. Retention/disenrollment

Successes During the fourth quarter of this fiscal year, a new process for re-enrollment was implemented. No longer would face-to-face interviews or income documentation be required. Current procedure uses a pre-printed form that is mailed to the enrolled child's family, and the information is verified, signed, dated, and returned.

Barriers The pre-printed form is not as user friendly as the initial application. A workgroup continues to address this issue.

5. Benefit structure

Successes The separate insurance program, KCHIP Phase III, has a rich benefit package, and it even includes a contract for vaccines. The benefit package is the same as Medicaid; except, it does not include non-emergency transportation and EPSDT Special Services.

Barriers The limitation of non-emergency transportation has proved to be a barrier for some families who may have to travel outside their counties for services. The rapid enrollment during the past year has put a strain on provider availability in some areas. An expanded and enhanced provider recruitment program has been implemented by the Department for Medicaid Services, and KCHIP has been a full participant in this effort. Provider recruitment has become an on-going effort.

6. Cost-sharing

Kentucky has not implemented cost sharing.

7. Delivery systems

Successes An important success has been the development of dental recruitment efforts. It is still an issue and will require continued efforts, but more dentists have become providers because of the recruitment program. A dentist has been hired by the Cabinet for Health Services to make recommendations on policy and program issues and to serve as liaison with dental providers.

Barriers KCHIP uses the same delivery system as the Department for Medicaid Services which has simplified implementation of KCHIP. No significant barriers have been noted that are attributed to KCHIP.

8. Coordination with other programs

Successes There are a number of state and local offices that have worked closely with the KCHIP program. Any listing will be incomplete, but several to list are local health departments, local schools, and the family resource youth service centers who have been instrumental in operating successful outreach efforts. Also, the Commission for Children with Special Health Care Needs and Kentucky's Early Intervention System have conducted statewide campaigns to enroll qualified children with special needs. Delivery of services has been enhanced because of the coordination with the Department for Medicaid Services' delivery system and Division of Epidemiology and Health Planning's vaccine program. Also, landmark comprehensive early childhood legislation was passed during the 2000 legislative session that will have a significant impact on children's health.

Barriers The one barrier that has been noted is the result of our success; i.e., rapidly increasing enrollment has strained provider resources in some areas. It is an issue that has been discussed and is being addressed.

9. Crowd-out

Successes Kentucky uses a six month waiting period to control for crowd-out, and it appears to be an effective method.

Barriers This is an area of the program that continues to be controversial and is one that requires more evaluation.

10. Other

Success The most significant success has been that KCHIP has achieved full implementation within the prescribed time frames.

Barrier One barrier that has been discussed is that KCHIP does not cover children who are older than 18 but are still dependents because they are continuing their formal education and training.

SECTION 4. PROGRAM FINANCING

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

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

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

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Net Benefit Costs	72,321,101	94,471,298	97,767,227
Administration Costs			
Personnel	814,200	875,100	875,200
General administration/operating	35,000	38,500	38,500
Contractors(e.g., enrollment)	1,200,000	1,200,000	1,200,000
Outreach/marketing costs	894,000	894,000	894,000
Other	369,125	3,384,700	3,384,600
Total Administration Costs	3,312,325	6,392,300	6,392,300
Federal Share (multiplied by enhanced FMAP rate)	60,037,814	79,954,574	82,244,363
State Share	15,595,612	20,909,024	21,915,164
TOTAL PROGRAM COSTS	75,633,426	100,863,598	104,159,527

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

NA

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

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations (such as United Way, sponsorship)
- Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

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

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

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	KCHIP Phase I & Phase II	KCHIP Phase III
Provides presumptive eligibility for children	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 90 days. There is an exception. If the applicant lives in the one managed care region in the state, eligibility dates back to the first day of the month that the application is received.	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 90 days. There is an exception. If the applicant lives in the one managed care region in the state, eligibility dates back to the first day of the month that the application is received
Makes eligibility determination	<input type="checkbox"/> State Medicaid eligibility staff <input checked="" type="checkbox"/> Contractor (Dept. for Community-Based Services) <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> State Medicaid eligibility staff <input checked="" type="checkbox"/> Contractor (Dept. for Community-Based Serv) <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____
Average length of stay on program	Specify months <u>6.4</u> *	Specify months <u>5.3</u> *
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
*Rapid enrollment has affected average length of stay Can apply for program over phone	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>6</u> What exemptions do you provide? Children whose insurance coverage has been terminated for reasons other than voluntary action by them or their parents; e.g., loss of employment, death of a parent, divorce, change of employment, change of address so that no employer-sponsored coverage is available, employer discontinues health benefits, expiration of COBRA, self-employment, and termination of health benefits due to long term disability.	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>6</u> What exemptions do you provide? Same as the medicaid expansion.
Provides period of continuous coverage <u>regardless of income changes</u>	<input checked="" type="checkbox"/> No There is an exception. If the enrolled child lives in the one managed care region of the state, there is continuous eligibility for 6 months. <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	<input checked="" type="checkbox"/> No There is an exception. If the enrolled child lives in the one managed care region of the state, there is continuous eligibility for 6 months. <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____
Imposes copayments or	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
coinsurance	_____ Yes	_____ Yes
Provides preprinted redetermination process	<p>_____ No</p> <p><input checked="" type="checkbox"/> Yes, we send out form to family with their information precompleted and:</p> <p style="padding-left: 40px;"><input checked="" type="checkbox"/> ask for a signed confirmation that information is still correct</p> <p style="padding-left: 40px;">_____ do not request response unless income or other circumstances have changed</p>	<p>_____ No</p> <p><input checked="" type="checkbox"/> Yes, we send out form to family with their information and:</p> <p style="padding-left: 40px;"><input checked="" type="checkbox"/> ask for a signed confirmation that information is still correct</p> <p style="padding-left: 40px;">_____ do not request response unless income or other circumstances have changed</p>

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

SECTION 6: INCOME ELIGIBILITY

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

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

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

185% of FPL for children under age 1
133% of FPL for children aged 1 through 5
100% of FPL for children aged 6 through 15

Medicaid SCHIP Expansion

100% of FPL for children aged 16 through 18
150% of FPL for children aged 1 through 18
____% of FPL for children aged _____

State-Designed SCHIP Program

200% of FPL for children aged Birth through 18
____% of FPL for children aged _____
____% of FPL for children aged _____

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

A work expense standard deduction of \$90 is applied to the gross monthly income of each employed individual’s wages for either full-time or part-time employment. A deduction for childcare is allowed for children under age 14, and for children 14 and over if care is necessary for safety of the child. The maximum deduction for children under age 2 is \$200. The deduction for children over age 2 is \$150 for parents employed part-time and \$175 for parent/s employed full-time, and a similar deduction is applied if care is required for a disabled adult living the home while the parent/s work.

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) Yes No
 If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	\$ 90	\$ 90	\$ 90
Self-employment expenses – <i>Losses, depreciation, taxes</i>	\$ Depends	\$ Depends	\$ Depends
Alimony payments Received	\$ NA	\$ NA	\$ NA
Paid	\$ NA	\$ NA	\$ NA
Child support payments Received	\$	\$	\$
Paid – <i>Deduction is what is paid</i>	\$ Depends	\$ Depends	\$ Depends
Child care expenses	\$ Up to \$200	\$ Up to \$200	\$ Up to \$200
Medical care expenses – <i>Only if aged, blind or disabled</i>	\$ NA	\$ NA	\$ NA
Gifts	\$ NA	\$ NA	\$ NA
Other types of disregards/deductions (specify)	\$	\$	\$

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

Title XIX Poverty-related Groups	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test _____
Medicaid SCHIP Expansion program	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test _____
State-Designed SCHIP program	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test _____
Other SCHIP program _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test _____

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

SECTION 7: FUTURE PROGRAM CHANGES

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

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

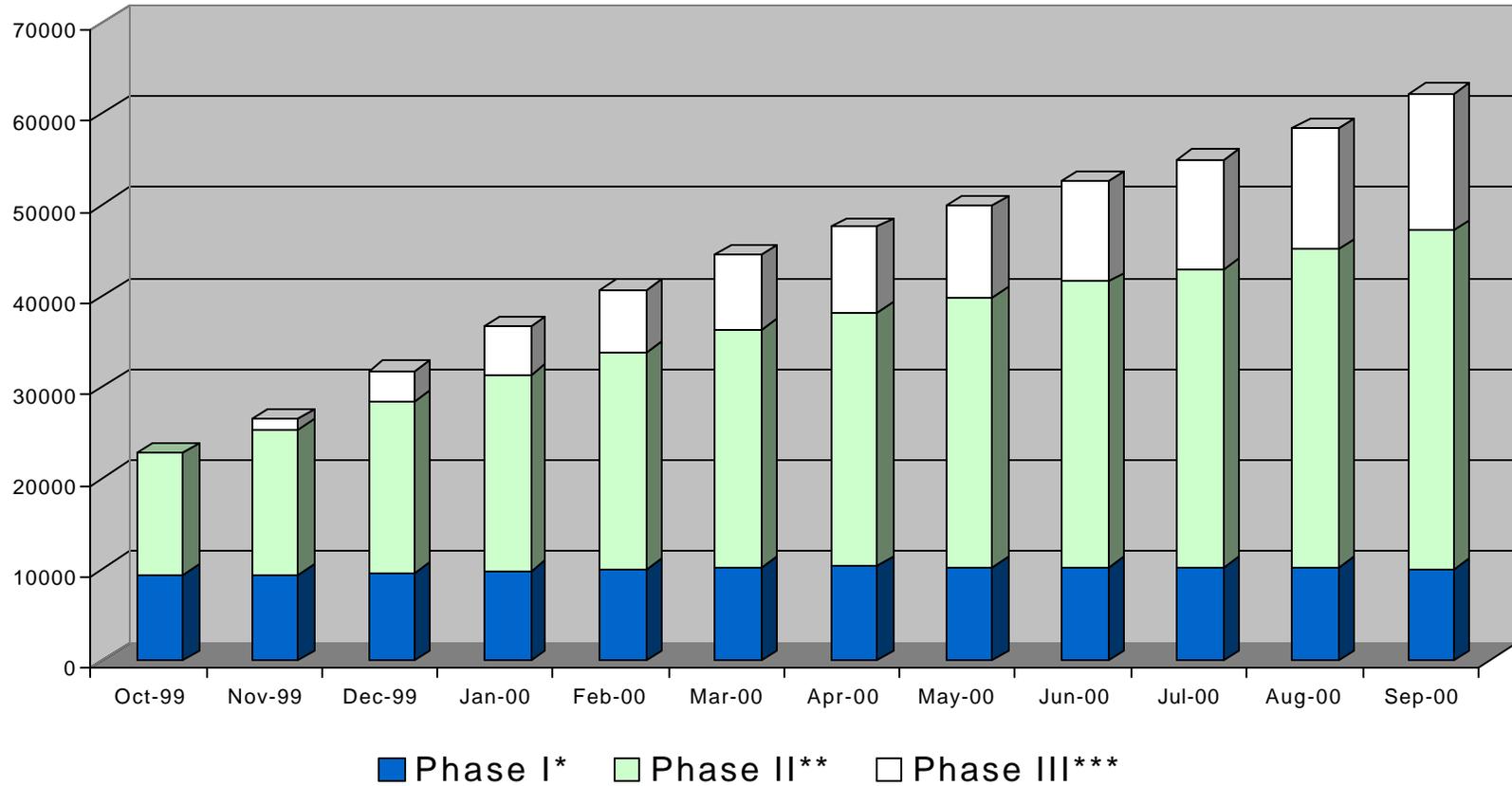
1. Family coverage
2. Employer sponsored insurance buy-in
3. 1115 waiver
4. Eligibility including presumptive and continuous eligibility
5. Outreach
6. Enrollment/redetermination process
7. Contracting
8. Other

APPENDICES

Appendix A	KCHIP Cumulative Enrolled Children
Appendix B	Quarterly Enrollment Comparison for FFY99 & FFY00
Appendix C	Rate of Uninsured Children Declines
Appendix D	Baselines Kentucky Medicaid Well-Child Visits Passport Well-Child Visits First 15 Months Passport Well-Child Visits 3-6 th Year & Adolescent Passport Childhood & Adolescent Immunizations

KCHIP Cumulative Enrolled Children

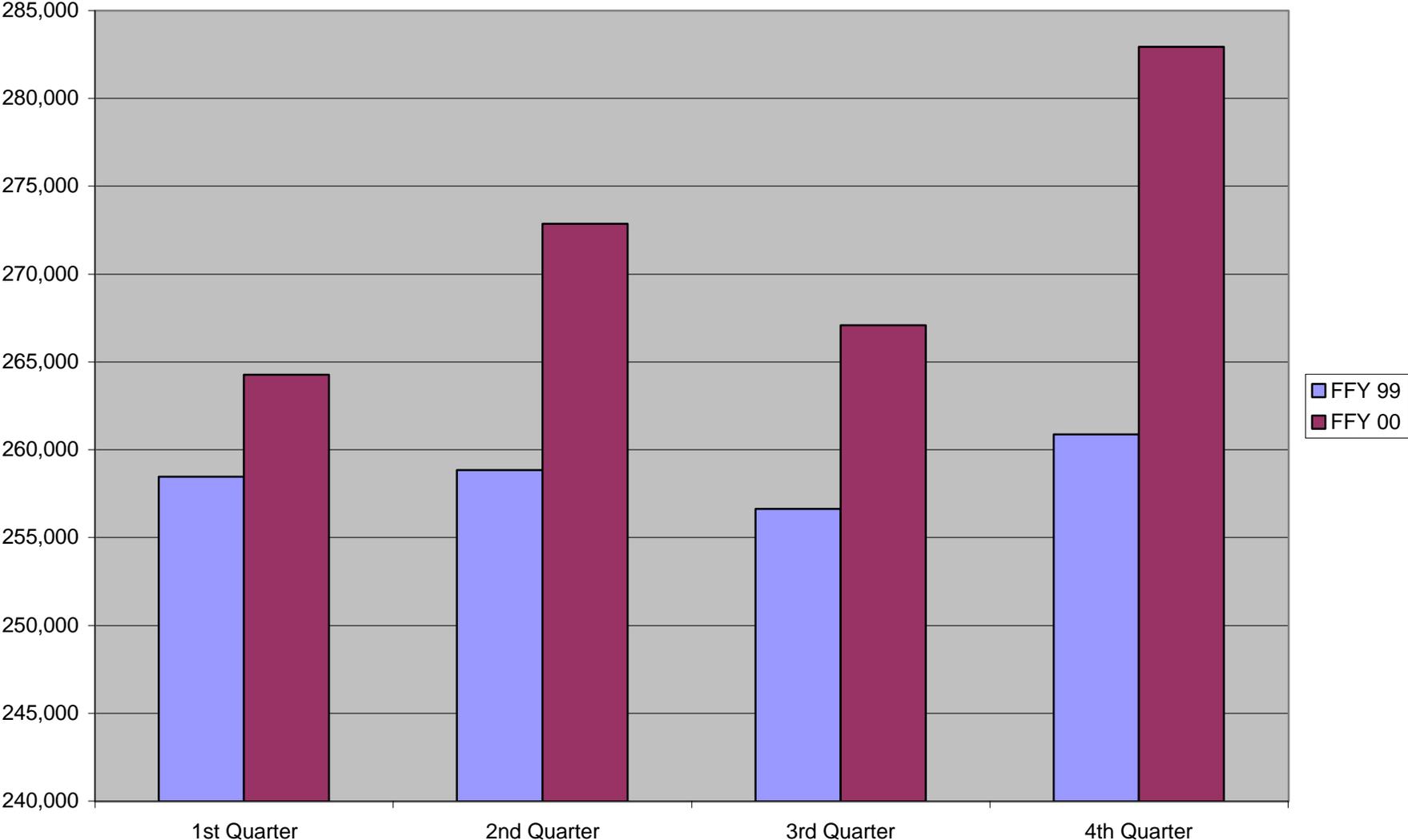
October, 1999-September, 2000



	Oct-99	Nov-99	Dec-99	Jan-00	Feb-00	Mar-00	Apr-00	May-00	Jun-00	Jul-00	Aug-00	Sep-00
Phase I*	9464	9528	9698	9910	10053	10271	10339	10248	10274	10229	10271	10060
Phase II**	13272	15879	18776	21477	23782	26115	27908	29585	31217	32731	34773	37083
Phase III***		1110	3309	5327	6783	8125	9184	10059	11104	12031	13325	14967
Total	22736	26517	31783	36714	40618	44511	47431	49892	52595	54991	58369	62110

*Cumulative data beginning July 1, 1998
 **Cumulative data beginning July 1, 1999
 ***Cumulative data beginning November 1, 1999

Quarterly Enrollment in Medicaid for Children Under 19 from the Beginning of KCHIP



About the Baselines

January 2000

- Baseline measures are useful for monitoring and evaluating changes in health care service delivery and health outcomes.
- The baselines represented here are based on activity prior to the establishment of the Health Care Partnerships (either fiscal or calendar year 1997). Additional baselines on other disease specific topics will be measured as part of our health initiatives.
- These baselines were adopted from the effectiveness of care and service utilization measures from the Health Plan Employer Data and Information Set 3.0 (HEDIS).
- HEDIS measures do not calculate the total number of services performed by the plans. HEDIS measures are designed specifically for comparison of data across managed care plans and generally only include members who are continuously enrolled for a specified time period and who meet specified age, gender and clinical parameters. The national HEDIS measures presented were originally developed for commercial health plans and may or may not include Medicaid or Medicare enrollees.

Source: Department for Medicaid Services
Division of Quality Improvement
275 East Main Street
Sixth Floor, MS6-EB
Frankfort, KY 40621-0001
Phone: 502-564-7940
Fax: 502-564-3232
<http://cfc-chs.chr.state.ky.us/chs/dms>

BASE-99-01

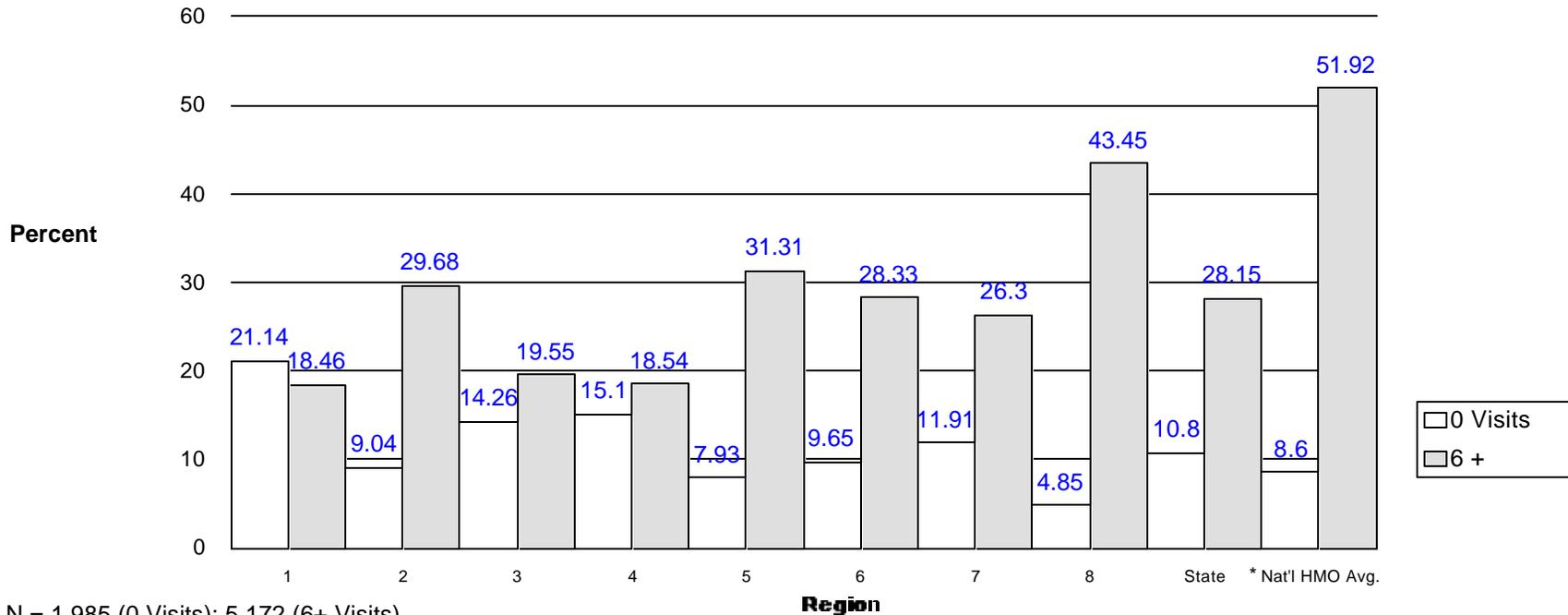
Kentucky Medicaid Well-Child Visits in the First 15 Months of Life FY 1997
Percent of Eligible Children Who Received 0 or 6 or More Well-Child Visits by 15 Months of Age
Based on NCQA HEDIS

The American Academy of Pediatrics recommends that infants have a total of 10 primary care visits in their first 18 months of life. Each of the visits includes an assessment with a recommended set of measurements, screenings, developmental and behavioral assessments, immunizations, and anticipatory guidance (*American Academy of Pediatrics, The American College of Obstetricians and Gynecologists*). The purpose of the recommended preventive care visits is to totally avoid, reverse, or minimize chronic or disabling complications and their impact on children and their families. These routine recommended visits allow health care professionals an opportunity to assess for developmental delays, sensory impairments, and other disorders that may not be obvious to a child's parents. Approximately 12% of all children have developmental delays, which can interfere significantly with academic success and life functioning. Early intervention has been shown to improve family functioning, child behavior, adult outcomes and socioeconomic status.

This indicator measures the percentage of Medicaid enrolled members who turned 15 months old during the reporting year, who received either zero, or six or more well-child visits with a primary care practitioner during their first 15 months of life. NOTE: This measure is similar to the Early and Periodic Screening Diagnosis and Treatment (EPSDT) measure; however, this indicator measures different age groupings and does not capture EPSDT's referral process.

Denominator: Medicaid enrolled members who turned 15 months old during the reporting year and who were continuously enrolled in the plan from 31 days of age.

Numerator: Those receiving either zero (0) or six or more well-child visits with a primary care provider during their first 15 months of life. Members who have had no more than one gap in enrollment of up to 45 days during the continuous enrollment period should be included in this measure.



N = 1,985 (0 Visits); 5,172 (6+ Visits)

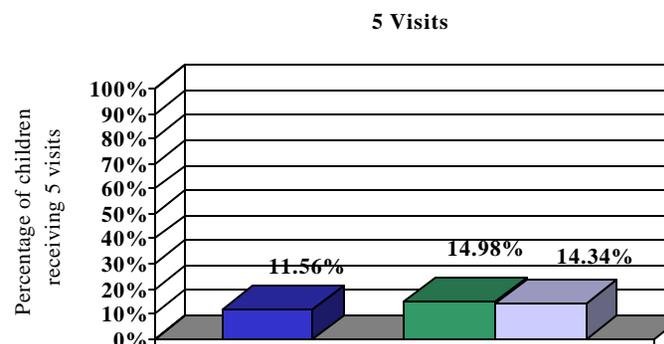
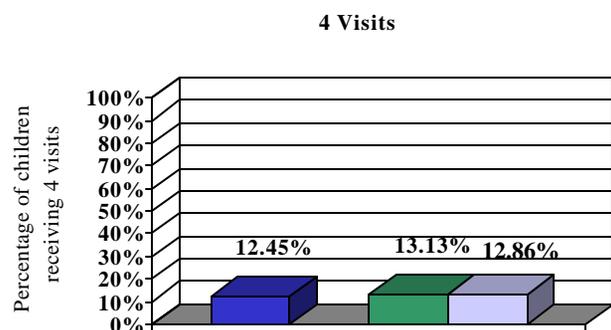
* Source: HEDIS 1998 Commercial Plan Comparisons; Prepared by: Kentucky Department for Medicaid Services (12/21/99; sh/wellchil.pr4)

HEDIS Results for Well-Child Visits in the First 15 Months of Life

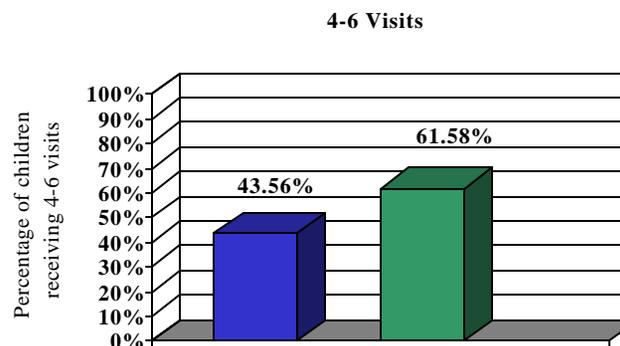
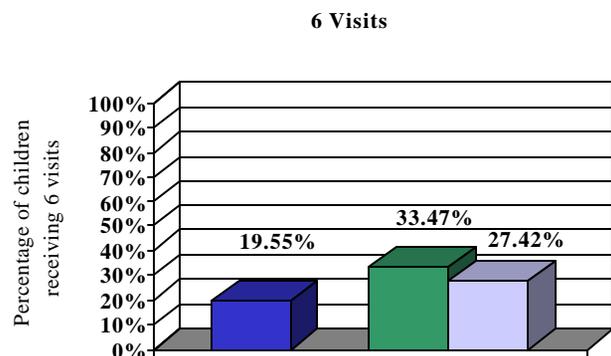


Administered by
AmeriHealth MERCY

The denominator for the measure includes members who turned 15 months old during the reporting year and who were continuously enrolled from 31 days of life. The numerator includes those children who received 4 or more visits within the first 15 months of life.



- 1997 Region 3 State Results
- 1998 Region 3 Passport Results*
- 1999 Region 3 Passport Results
- 1998 NCQA Nationally Reported Medicaid Mean**



	Numerator	Denominator
4-6 Visits	2,055	3,337

*1998 Region 3 outcomes not available as the membership was administered by both the State and Passport Health Plan during the reporting period.
 **1998 NCQA Nationally Reported Medicaid Mean not available for combined rate of 4 to 6 visits.

Focused efforts on EPSDT compliance resulted in increased preventive care for children. Passport has increased the percentage of children receiving 4 or more visits by 41% from when benefits were administered by the State in 1997. Four, five, and six visits rates exceed the NCQA nationally reported Medicaid mean. *These results are not comparable to EPSDT rates due to differences in methodology.*

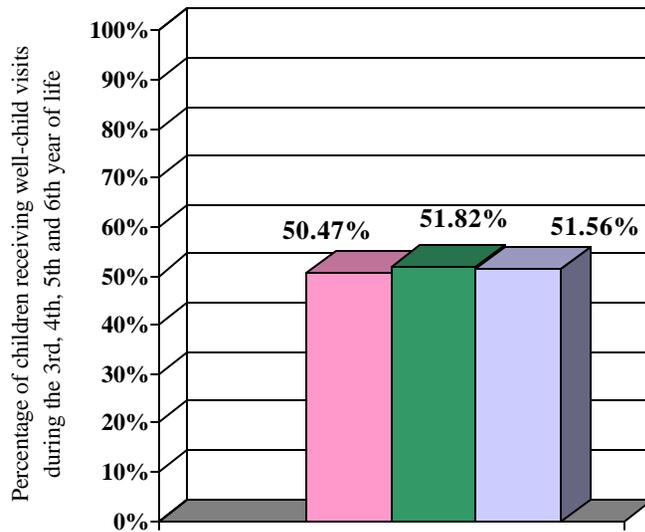
HEDIS Results for Well-Child Visits in the 3rd, 4th, 5th and 6th Year of Life and Adolescent Well-Care Visit



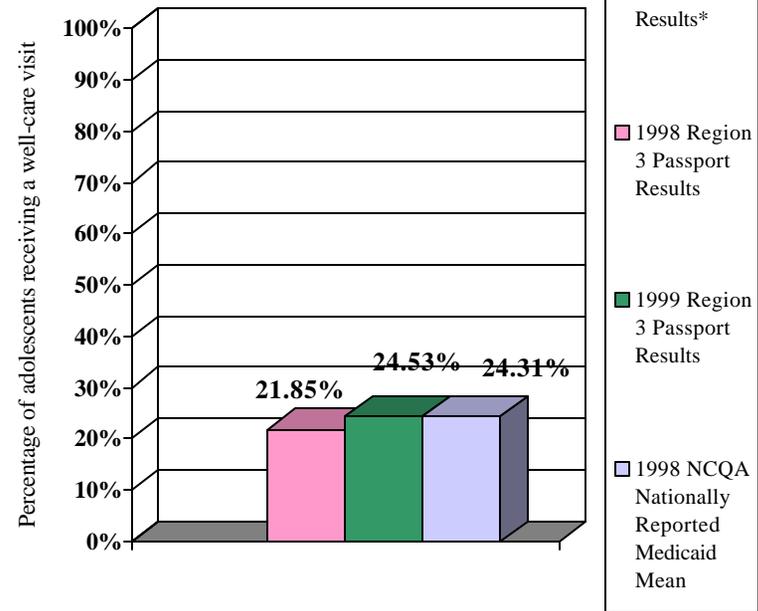
Administered by
AmeriHealth MERCY

The measure for well-child visits in the 3rd, 4th, 5th, and 6th year of life includes members age 3 through 6 who were continuously enrolled during the measurement year and received one or more well-child visit with a PCP. The measure for adolescent well-child visits includes members age 12 through 21 years who were continuously enrolled during the measurement year and received at least one comprehensive well-care visit with a PCP or OB/GYN.

**Well-Child Visits in the 3rd, 4th,
5th and 6th Year of Life**



Adolescent Well-Care Visits



	Numerator	Denominator
3-6 yrs	5,147	9,933
Adolescents	2,879	11,736

**1997 Region 3 State results were not reported.*

Rates of preventive care for children and adolescents essentially unchanged during reporting periods. Screening rates comparable to NCQA nationally reported Medicaid mean for both age groups. *These rates are not comparable to EPSDT rates due to differences in methodology.*

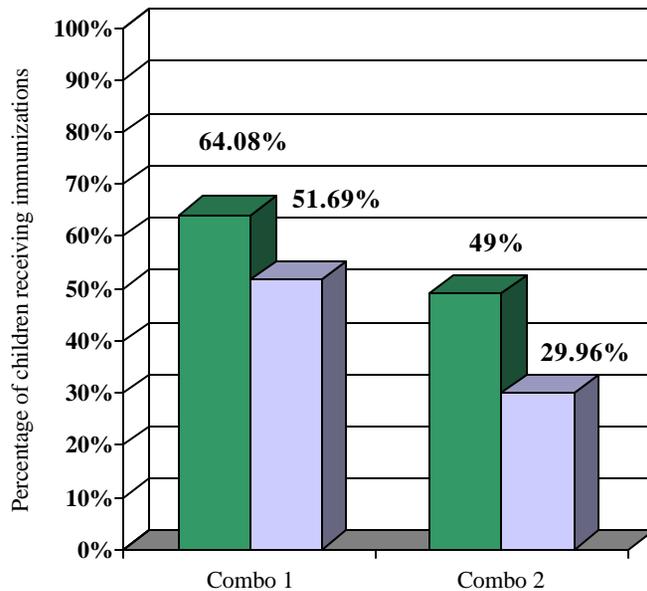
HEDIS Results for Childhood and Adolescent Immunizations



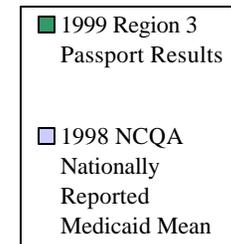
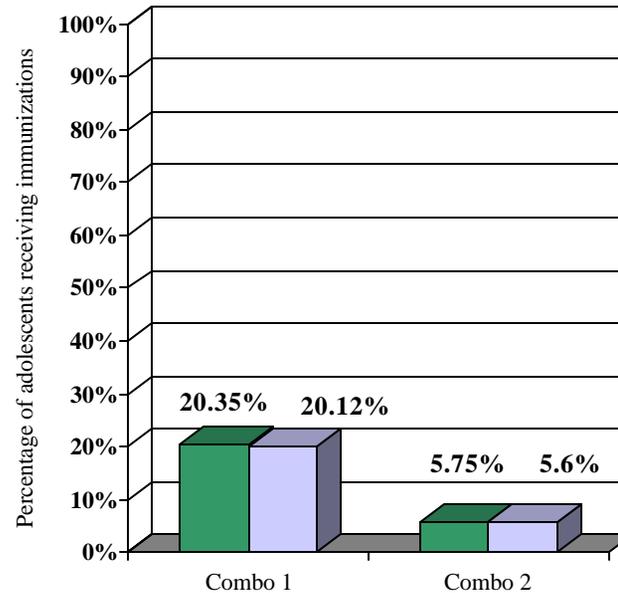
Administered by
AmeriHealth MERCY

The measure for childhood immunizations includes children turning two years old during the measurement year, who were continuously enrolled for 12 months prior to their second birthday. Combo 1 is defined as children who have received four DTP or DTaP vaccinations, three polio vaccinations, one measles, mumps and rubella vaccination, two H influenza type b vaccinations and three hepatitis B vaccinations. Combo 2 is defined as children who have received all vaccinations listed in combo 1 and at least one chicken pox vaccination. The measure for adolescent immunizations includes adolescents turning 13 during the measurement year, who were continuously enrolled for 12 months prior to their 13 birthday. Combo 1 is defined as adolescents who have received their second measles, mumps and rubella vaccination and three hepatitis B vaccinations. Combo 2 is defined as adolescents who have received all vaccinations listed in combo 1 and at least one chicken pox vaccination.

Childhood Immunizations



Adolescent Immunizations



	Eligible Population	Sample Size
Childhood	2,784	451
Adolescent	1,643	452

*1997 The State chose not to report this measure

** 1998 Region 3 outcomes not available as the membership was administered by both the State and Passport Health Plan during the reporting period.

Passport has exceeded the NCQA nationally reported Medicaid mean for combo 1 and 2 rates for children and is in line with the nationally reported Medicaid mean for combo 1 and 2 rates in adolescents.