

***Federal Fiscal Year 2001
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:

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

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 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, 2000, 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.

A. Program eligibility

NC

B. Enrollment process

Effective June 2001, the Department for Medicaid Services (DMS) resumed the process of requiring that written verification of income and proof of childcare expenses be included with the KCHIP/ Medicaid initial mail-in application.

C. Presumptive eligibility

NC

D. Continuous eligibility

NC

E. Outreach/marketing campaigns

When KCHIP was launched in July 1999, it included an extensive media campaign with TV, radio and print in combination with local outreach through public health. As the program has matured, outreach efforts have focused on retention of eligible children as well as seeking out and enrolling new eligibles. The outreach emphasis has also switched from state-defined outreach activities to support of community-based outreach initiatives with major emphasis at the grassroots level. Future directions will shift to the improvement of children's health by assuring that every child has a medical home and receives appropriate preventive and primary care and that parents are educated on the effective use of the health care delivery system.

F. Eligibility determination process

Department for Medicaid Services continues to use the mail-in application for initial eligibility determination and has resumed the process of requiring that written verification of income and proof of childcare expenses be used when determining eligibility.

G. Eligibility redetermination process

Effective June 2001, KCHIP and Medicaid resumed the requirement for face-to-face interviews and verification of income and expenses for recipients at the time of their KCHIP/Medicaid recertification.

H. Benefit structure

NC

I. Cost-sharing policies

NC

J. Crowd-out policies

In accordance with 42 CRF 457.800(h) Substitution of Coverage, Kentucky will no longer require a six-month waiting period for families who have voluntarily dropped health insurance for its Medicaid Expansion Program (children up to and including 150% FPL). Kentucky's current contract with its eligibility vendor continues through June 30, 2002. Effective with the new contract (July 1, 2002), the updated crowd out policy will apply.

K. Delivery system

The service delivery system for the KCHIP Medicaid expansion and the separate insurance program continues to be the same as for all Medicaid recipients, and the Primary Care Case Management (PCCM) program known as KenPAC has expanded. Medicaid and KCHIP recipients are offered a choice of PCCM providers and served through the KenPAC program statewide under the provisions of the Balanced Budget Act (BBA) of 1997. In one region of the state (surrounding Louisville), services are provided to Medicaid and KCHIP recipients through a Health Care Partnership, the Passport Healthcare Plan.

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

NC

M. Screen and enroll process

NC

N. Application

NC

O. Other

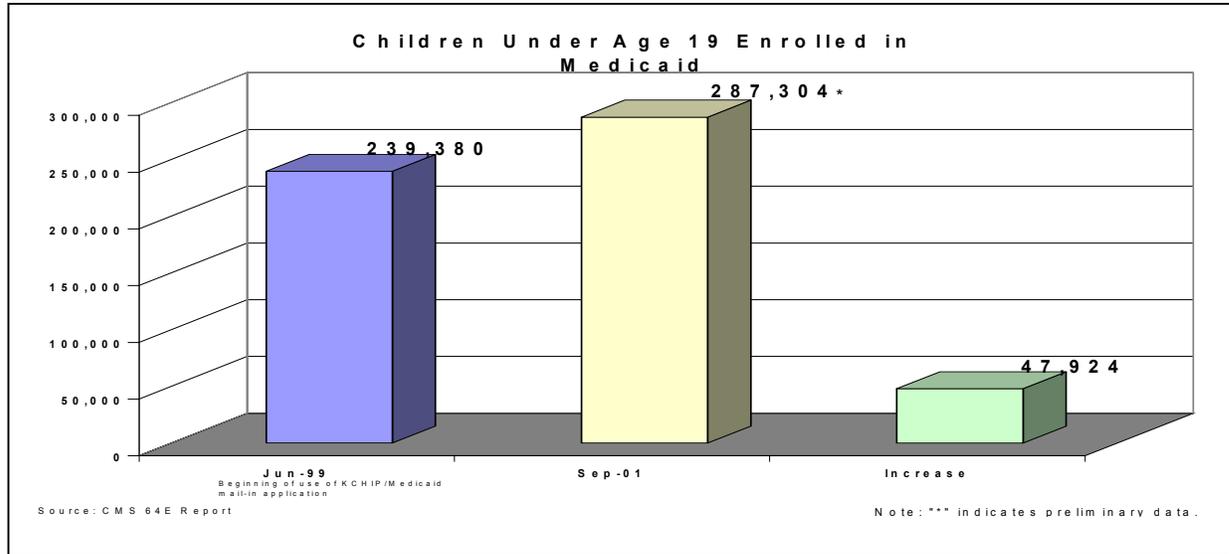
1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

Current enrollment in KCHIP for FFY 2001 began at 50,396 and grew to 51,120 by the end of September 2001. The overall increase (1.4%) does not accurately reflect the 6% increase that is taking place in the second Medicaid Expansion program (Phase II) or the 13% increase in enrollment that is taking place in the separate insurance program (Phase III). In the Medicaid Expansion (Phase I), there has been a 42% decrease in enrollment due to an aging out process. Phase I is aging out into traditional Medicaid and will complete the transition by October 2002. A corresponding chart with current monthly enrollment by each of the KCHIP phases is included in Appendix A.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The Kentucky Legislative Research Commission conducts a study each year on the number of uninsured low-income children in Kentucky. The report encompassing FFY01 has not yet been published. In absence of the report, see the U.S. Census Bureau data below (item C).

- B. 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.

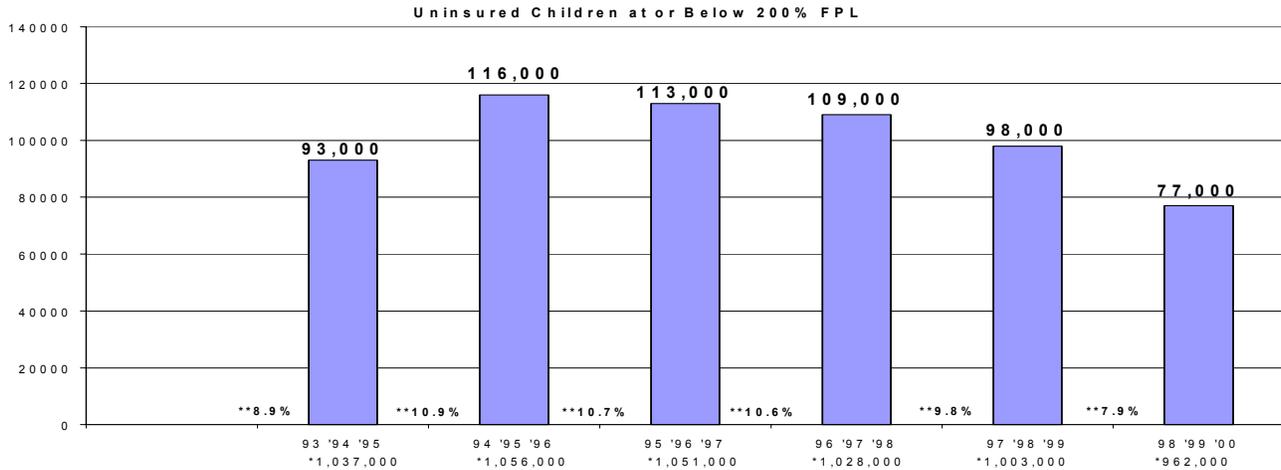


KCHIP's joint mail-in process and aggressive outreach began in July 1999. As of the preceding month, there were 239,380 children enrolled in the Medicaid program. By the end of September 2001, there were 287,304 (preliminary data) children enrolled in Medicaid. This is an increase of 47,924 (17%) enrolled children. The growth in the number of enrolled children is not the sole result of SCHIP outreach, but enrollment has accelerated due to SCHIP outreach. The source of this data is the CMS 64E report.

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

According to the U.S. Census Bureau, there were 113,000 uninsured children at or below 200% FPL and under 19 years of age in Kentucky prior to implementation of KCHIP (based on three-year average for 1995, 1996 and 1997). The three-year average for 1998, 1999 and 2000 is 77,000-- a decrease of 36,000 (32%).

Kentucky Uninsured Children
Three Year Averages



*Total children under 19 years, all income levels.
**Percentage of children, under 19 years, all income levels, at or below 200% FPL without health insurance.

Source: U.S. Census Bureau, 11-29-2001
<http://www.census.gov/hhes/hlthins>

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

No, skip to 1.3

Yes, what is the new baseline?

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

What was the justification for adopting a different methodology?

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

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

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 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 and 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 “NC” (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. ▪ KCHIP did achieve this objective and more so within the first two years. ▪ For the third year, it was projected we would reach 75% penetration rate. 	Data Sources: <ul style="list-style-type: none"> ▪ Medicaid and KCHIP enrollment data ▪ U.S. Census Bureau data ▪ KY Legislative Research Commission (LRC) annual insurance studies. Methodology: <ul style="list-style-type: none"> ▪ The Census Bureau uses calculated averages from 3-year averages. We use the averages from 1995/1996/1997 to serve as the baseline and from 1998/1999/2000 to determine our most current results. ▪ The LRC study uses calculated averages from the information provided by the U.S. Census Bureau and

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.)
		<p>augments it by the LRC household survey.</p> <p>Progress Summary:</p> <ul style="list-style-type: none"> ▪ KCHIP continues to exceed the performance goal that was met in FFY1999. ▪ As of September 30, 2001, a total of 85,264 children had been enrolled in the three phases of KCHIP since the beginning of the program on July 1, 1998. ▪ As of September 30, 2001, 23,550 children had been enrolled in the separate insurance program. ▪ As of September 30, 2001, 61,714 children had been enrolled in the Medicaid expansion. ▪ While information from the LRC was available for the last two reports, it is unavailable in time for this report. ▪ According to the U.S. Census Bureau, the number of uninsured children at or below 200% FPL and under 19 years of age decreased by 32% (from 113,000 down to 77,000) when comparing 1995/1996/1997 to 1998/1999/2000 averages.

Objectives Related to Increasing Medicaid Enrollment		
Within two years increase Medicaid enrollment	An additional 10,000 currently Medicaid eligible children will be enrolled in Medicaid.	Data Sources: <ul style="list-style-type: none"> ▪ Administrative enrollment data Methodology: <ul style="list-style-type: none"> ▪ Compare June 1998 and September 2001 current segment enrollment numbers. Progress Summary: <ul style="list-style-type: none"> ▪ The performance goal was met as of November 1, 1999. As of the end of FFY 2001, we continue to exceed the goal. In June 1998 there were 245,797 children enrolled in Medicaid, and in September 30, 2001, there were 287,304 enrolled, a net increase of 41,507 (14.5%) enrolled children.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
		Data Sources: Methodology: Progress Summary:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

<p>Within five years increase health status of children.</p>	<p>A. 90% of children covered under KCHIP will have complete immunizations by age 3,</p> <p>B. 95% of 13 year olds in KCHIP will have complete immunizations,</p> <p>(U.S. Immunization Survey 2000 shows Kentucky's immunization rate to be 81.4% (4-3-1 series) and 77% (4-3-1-3-3 series).</p> <p>C. 75% of children under 18 months of age will receive the recommended number of well child visits</p> <p>D. 75% of children between 3 and 6 years of age will receive at least one well child exam,</p> <p>E. 75% of children 12-17 years of age will receive at least one well child exam</p>	<p>Data Sources: After exploring using other methods, our best resources for determining baselines are the CMS 416 Report (Participation Ratios) and the MCO's (Passport Health Plan's) 2000 Health Outcomes and Member Satisfaction Results annual report. (Passport serves one region of Kentucky's Medicaid population which includes KCHIP.)</p> <p>Methodology: (See Data Sources above and the Performance Objective Data Elements for KCHIP Annual Evaluation in Appendix B)</p> <p>Progress Summary:</p> <p>A.1.1 (MCO) 65.85% of children turning two years old during the measurement year (CY2000) received all American Academy of Pediatrics (AAP) recommended immunizations excluding the chicken pox vaccine.</p> <p>A.1.2 (MCO) 57.21% of children turning two years old during the measurement year (CY2000) received all AAP recommended immunization including the chicken pox vaccine.</p> <p>A.2.1 (PCCM) Inadequate data for baseline. Plan to survey KCHIP parents to determine percentage.</p> <p>B. 1.1 (MCO) 28.22% of adolescents turning 13 years old during the measurement year (CY2000) received all AAP recommended immunizations excluding the chicken pox vaccine.</p> <p>B.1.2 (MCO) 9.56% of adolescents turning 13 years old during the measurement year (CY2000) received all AAP recommended immunization including the chicken pox vaccine.</p> <p>B.2.1 (PCCM) Inadequate data for baseline. Plan to survey KCHIP parents to determine %.</p> <p>C. 1.1 (MCO) 48.91% children who turned 15 months old during the measurement year (CY2000) received six or more well-child visits within the first 15 months of life.</p> <p>C.2.1 (PCCM) 80% of children up to 12 months of age received at least one well-child visit during the measurement year (FFY2000).</p> <p>C.2.2 (PCCM) 56% of children between one and two years of age received at least one well-child visit during the measurement year (FFY2000)*.</p> <p>D.1.1 (MCO) 54.58% of children between 3 and 6 years of age received one or more well-child visits during the measurement year (CY2000).</p> <p>D.2.1 (PCCM) 50% of children of between 3 and 5 years of age received at least one well-child visit during the measurement year (FFY2000).</p> <p>D.2.2 (PCCM) 34% of children of between 6 and 9 years of age received at least one well-child visit during the measurement year (FFY2000).</p> <p>E.1.1 (MCO) 30.66% of adolescents 12- 21 years of age during the measurement year (CY2000) received at least</p>
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	<p>receive at least one well child exam annually,</p> <p>F. 75% of children will receive routine vision screening yearly by PCP,</p> <p>G. 75% of children will receive an eye exam by an eye care specialist between ages 3-6.</p>	<p>one comprehensive well-child visit with a PCP or OB/GYN.</p> <p>E.2.1 (PCCM) 31% of adolescents 10-14 years old received at least one well-child visit during FFY 2000.</p> <p>E.2.2 (PCCM) 16% of adolescents 15-18 years of age (participation data) received at least one well-child visit during FFY2000. (Source: CMS 416 Report)</p> <p>F and G: (See item 1.6)</p>
<p>Other Objectives</p>		
<p>1. Within two years reduce barriers to affordable health coverage</p> <p>2. Within one year of HCFA plan approval, provide statewide coverage</p>	<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 for the state run Medicaid program. 	<p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Not applicable at this time ▪ KCHIP Annual Report for FFY98 to HCFA <p>Methodology:</p> <p>Progress Summary:</p> <ul 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.

We are using Region 3's managed care data for well-child visits and immunizations and will track MCO children separately from the rest of the state. Immunizations are more difficult to track for KCHIP children under Kentucky's PCCM model, KenPAC. The Department for Medicaid Services has been discussing alternative solutions to improve data collection and retention of records for immunizations with the Department for Public Health. No long-term solutions have been identified, and there is no statewide registry. Administrative data are used for tracking, but using this data source is problematic. We intend to use the CAHPS Survey (see item 1.7) to seek input from parents on the immunization status of the KCHIP children. We can

also use this tool for well-child visits. When we do the 416 report for EPSDT, we plan to do a shadow report for KCHIP well-child visits.

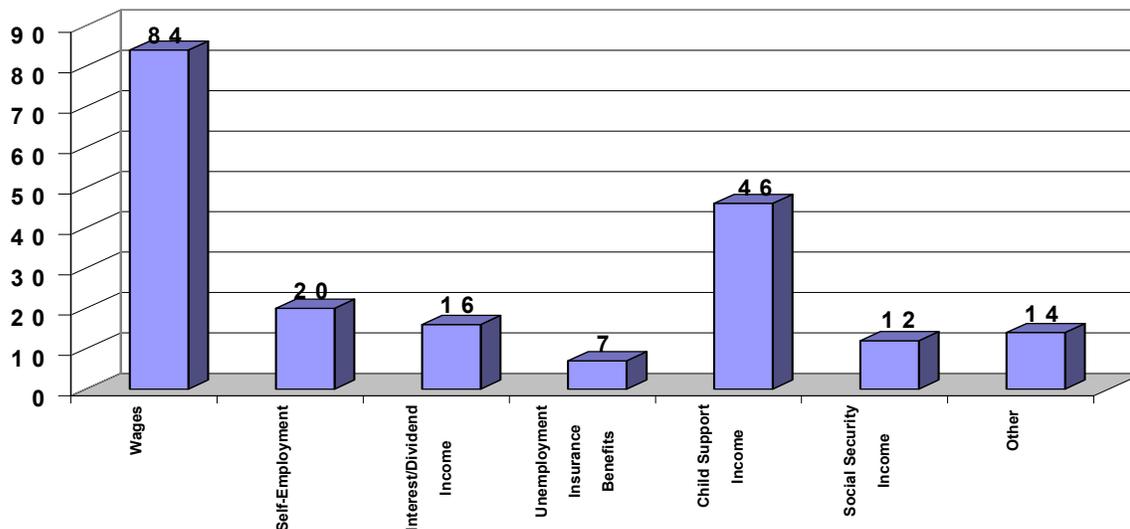
We are reassessing the performance goals for eye exams. We have not found a way to effectively measure for these two performance goals.

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.

- ***The Kentucky Childrens' Health Insurance Program (KCHIP) Recertification Survey SFY01 is a random sample, mailed survey conducted in January 2001. The survey was sent to recipients who had disenrolled during the months of August, September and October of 2000 to determine why the recipients were not re-enrolled, how their health care services are met (now and in the future) and their satisfaction with KCHIP services. Of the 1302 surveys sent to deliverable addresses, 548 individuals responded. See the complete Recertification Survey in Appendix C.***
- ***From October 2000 through September 2001, Kentucky conducted a Medicaid Quality Control Pilot Project targeting cases containing MCHIP children (children up to 150% FPL). The purpose of the project was to determine the validity of self-declaration of income and crowd-out issues. During the first eight months of the project, recipients mailed in enrollment or recertification applications and were not required to provide verification of income. Effective June 2001, they were required to provide income verification and those seeking to recertify were required to attend face-to-face interviews if they had not done so previously. (Initial applications with required income verification were still accepted if mailed in.) The Pilot looked at eligibility, including income, insurance and reasons for changes in insurance. Of the 1612 cases reviewed, 1461 (90.6%) were eligible for the KCHIP Medicaid Expansion Program and 151 (9.4%) were ineligible; and unreported income was discovered in 191 cases (see chart next page). (See the complete Preliminary Summary in Appendix D.)***

Medicaid Quality Control Pilot Project Findings

Types of Unreported Income (191 cases)



Source: Kentucky Cabinet for Families and Children, Office of Performance Enhancement, November 2001

- For the fourth year, the Kentucky Department for Medicaid Services commissioned researchers at the Martin School of Public Policy and Administration at the University of Kentucky (UK) to implement a satisfaction survey of Medicaid recipients in the Commonwealth, including KCHIP children. It is based on the CAHPS Survey (Consumer Assessment of Health Plans) which was developed by the Agency for Healthcare Research and Quality. It is now a part of the HEDIS measures and consists of a set of standardized questions that assess Medicaid recipients' satisfaction with the health care they have experienced.

The survey was designed to provide information about the satisfaction with services, health status, access to care, and utilization of health care of participants enrolled in Medicaid. The results are based on mail questionnaires for adult and child Medicaid recipients with about 100 items on each questionnaire. Over 4,680 surveys were sent to child Medicaid recipients, and KCHIP Medicaid expansion and separate insurance children were included in the sample. UK received back 1,612 child surveys for a response rate of 34 percent. Most surveys were received during May and June 2001.

The survey results indicate that child Medicaid recipients are generally satisfied

with their care across the state. Questions asked respondents to rate their personal providers, specialists, health care in general, and experiences with their health plan on a 0 to 10 scale, where 0 is "worst possible" and 10 is "best possible." Providers were rated an average of 8.3 from the child survey, specialists were rated an average of 8.5 and health services in general rated an average of 8.3. *A copy of the 2001 Medicaid Patient Satisfaction Survey and its Child Data Appendix are in Appendix E.*

- **The Kentucky Department for Medicaid Services also commissioned researchers at UK to implement a third satisfaction survey of Kentucky health care providers of Kentucky Medicaid patients, including KCHIP children. Over 2,000 surveys were mailed out and 500 providers responded**

When asked how they rated their freedom to make clinical decisions, respondents were provided with a scale of from one to five with one equaling "have almost no freedom" and five equaling "have almost complete freedom." The average rating was 3.5 for freedom to make clinical decisions, tests and procedures. Providers were also asked how dissatisfied or satisfied they were with the ability to provide the highest quality care possible. The question included a seven-point scale with one equaling "very dissatisfied" and seven equaling "very satisfied". The average rating was 4.5. Another asked providers to rate how healthy Medicaid patients are compared to private patients. Two-thirds (68%) of the providers believe Medicaid patients are less healthy.

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.

- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?
 - _____ Number of adults
 - _____ Number of children

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

2.2 Employer-sponsored insurance buy-in: NA

- A. 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).

- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?
 - _____ Number of adults
 - _____ Number of children

2.3 Crowd-out:

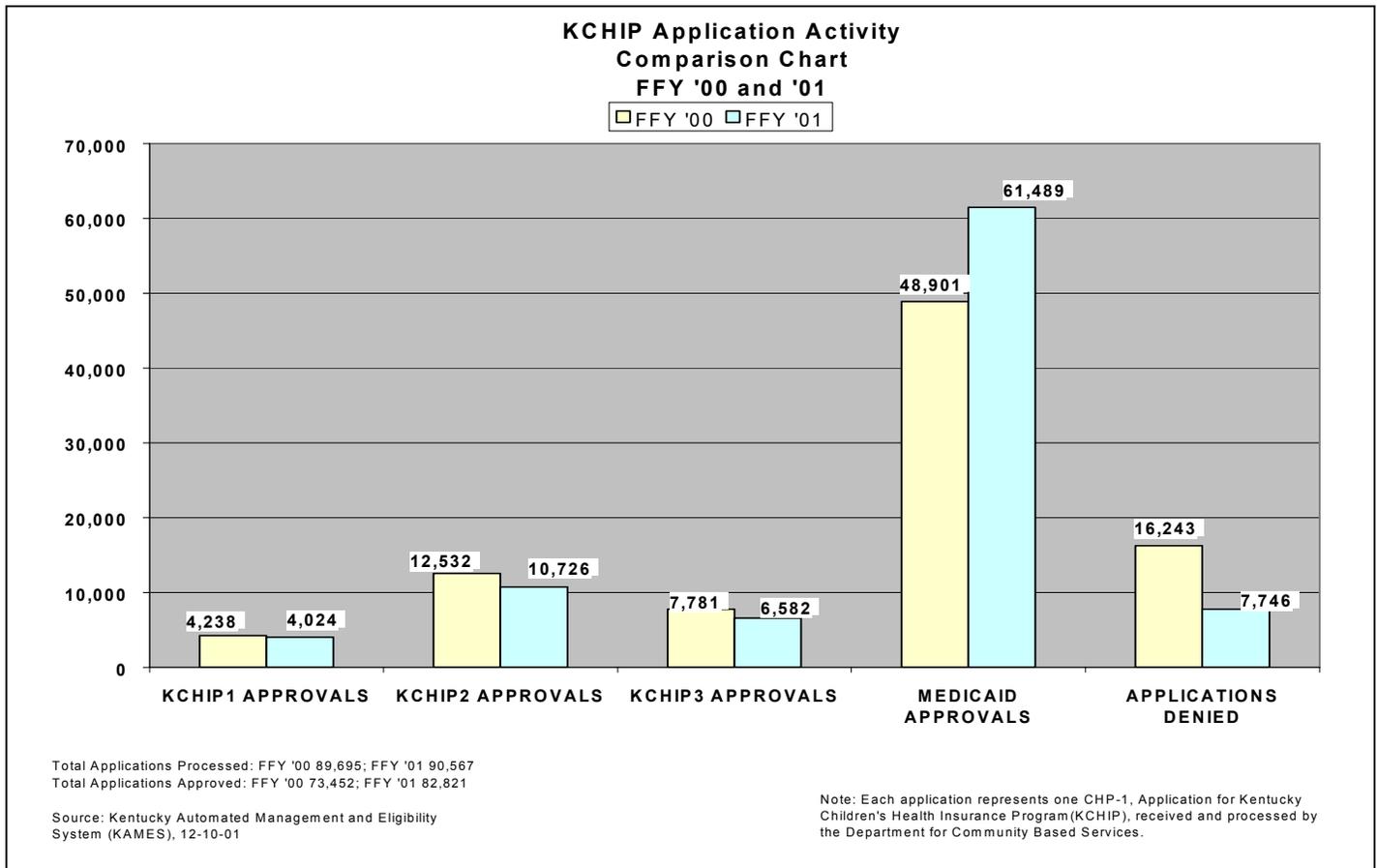
- A. How do you define crowd-out in your SCHIP program?

A child is ineligible if he/she has had private comprehensive health insurance coverage in the six months prior to the application. An application may be approved in cases where the coverage ended less than six months prior to determination of eligibility if coverage was terminated involuntarily 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 long term disability.

- B. 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. Beginning in October 2000, the Medicaid Quality Control Project was initiated for the KCHIP Medicaid Expansion Program (MCHIP) and one purpose of the study was to determine crowd-out. (For a copy of the preliminary findings, see Appendix D.)

- C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.
- We are monitoring on a monthly basis applications approved and denied. Out of a total of 90,567 applications during FFY 2001, there were more than 8,129 individual cases (7,746 families) denied. Twenty-eight percent of the denials were because the applicant failed to supply all the required information and documentation (see below). The second (19%) most frequent denial of an application was because the applicant failed to cooperate with agency, the third



reason (18%) was the applicant is currently receiving Medicaid, the fourth reason (17.8%) was the applicant's income exceeds the limits, and the fifth (10%) most frequent denial reason is because the applicant has health insurance.

- According to the state's Medicaid Quality Control Pilot Project (discussed initially under item 1.7) preliminary findings for cases reviewed in Kentucky's Medicaid expansion program, 1461 cases (90.6%) out of a possible 1612 cases were found eligible, and 151 (9.4%) were found ineligible. The ineligibles were identified due to the following reasons:
 - 86 - income exceeded agency guidelines
 - 48 - insurance was being carried on case members
 - 3 - no eligible child in the home/technical household composition error
 - 11 - multiple reasons (combination of the above)
 - 3 - other

(See the complete preliminary report in Appendix D.)

- D. 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 Department for Medicaid Services and collaborating agencies continue to reach as many children as possible in need of health insurance coverage through ongoing outreach efforts. Outreach activities are directed towards enrollment of new eligibles, retention of eligible children who are already enrolled and education of families about effective use of health services.

Some of the activities that have been most effective are: the annual Back-To-School campaign with a statewide news release on health and safety tips in conjunction with every school principal receiving a letter pertaining to KCHIP signed by the Commissioner for Education and the Secretaries for the Cabinets for Health Services and Families and Children; the annual Kentucky state fair with over 50,000 attendees at the Cabinet for Health Services' displays; and, communication with KCHIP outreach partners and distribution of information upon request. This included continuing regular communication through outreach work group meetings; providing application and other KCHIP promotional material upon request; giving KCHIP presentations at statewide meetings; and maintaining the KCHIP Website which averaged 5,791 hits per month during the last quarter of FFY2001.

How have you measured effectiveness?

The effectiveness of these efforts has primarily been measured by the increase in enrollment as well as the number of calls received at the 800 telephone numbers and mailed applications. Total cumulative enrollment of 85,264 in September 2001 exceeds the original estimated eligibles of 78,000 by more than 7,000.

- B. 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 continued in FY 01 with the UK Farmworker Outreach Program to target Latino and Hispanic populations. The contract provided translation services and outreach through Hispanic Health Fairs, conferences and small community events throughout 11 different counties. A 15-minute weekly radio program was aired on "Radio Vida". There were over 575 applications distributed and over 500 phone calls were received at the KCHIP 800 Spanish line. Also, the contract information specialist served as a link between the eligibility offices and Spanish speaking families to help translate and clarify information.

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

Specific data not available.

2.5 Retention:

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

We have found through both the *Kentucky Childrens' Health Insurance Program (KCHIP) Recertification Survey SFY2001* (whose respondents used the mail-in process for recertification) and through the Department for Community Based Services (the eligibility venter and point-of-contact for face-to-face interviews) that a large proportion of families chose not to recertify with either a mail-in process or a face-to-face process. It also appears that more than half of the recipients then go on to reenroll in either KCHIP or Medicaid within the next six months (57% according to the Recertification Survey). *For more details on the Recertification Survey, see item B, below and Appendix C.*

The Department for Medicaid Services continues to work through local health departments and our outreach partners to emphasize the importance of recertification in order to avoid a lapse in coverage whenever possible.

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

Follow-up by caseworkers/outreach workers

Renewal reminder notices to all families

Targeted mailing to selected populations, specify population

Information campaigns

Simplification of re-enrollment process, please describe

Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe. **See the KCHIP Recertification Survey SFY2001, Appendix C.**

Other, please explain

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

Yes, with the exception of the disenrollee survey.

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

A combination of approaches are most effective, i.e., mailing notices, follow-up phone calls, and face-to-face contact with local outreach workers.

E. 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.

According to the KCHIP Recertification Survey SFY2001, 19.3 % (102) of the respondents reported currently having group or private insurance, 57% (300) reported currently having Medicaid or KCHIP and 22.9% (121) reported having no insurance. The complete survey is included in Appendix C.

2.6 Coordination between SCHIP and Medicaid:

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

Yes, no change.

B. 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 that affect eligibility into the system; 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.

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

Yes, no change.

2.7 Cost Sharing:

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

Not applicable.

- B. 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?

Not applicable.

2.8 Assessment and Monitoring of Quality of Care:

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

See survey descriptions under item 1.7.

- B. 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?

Having explored other methods, our best resources for determining baselines are the CMS 416 Report and the MCO's (Passport Health Plan's) 2000 Health Outcomes and Member Satisfaction Results annual report. Passport is the MCO that services a 16-county region of Kentucky's Medicaid population that includes KCHIP. (See also the survey descriptions under item 1.7).

- C. 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 2001 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.

A. Eligibility

Successes: We are improving the accuracy of identifying recipients who are truly eligible through such tools as the *Medicaid Quality Control Pilot Project* and by requiring proof of income documentation. Through the Website and toll-free application acceptance number, we have made it easier for people to check on eligibility issues.

Barriers: Follow-up notices are difficult to understand (based on feedback from families). There is a work group convened by the Department for Community Based Services addressing this issue.

B. Outreach

Successes: Two state level outreach efforts that continue to be successful for KCHIP are the Kentucky State Fair and the annual back-to-school campaign as well as contracts with our KCHIP outreach partners: Department for Public Health for a statewide toll-free application assistance line and coordination of outreach efforts at the county level; University of Kentucky Farmworker Outreach Program for targeted outreach to the Hispanic populations; and the public relations firm for development of specified materials.

As the program has matured, outreach efforts have focused on retention of eligible children as well as seeking out and enrolling new eligibles. The outreach emphasis has shifted from state-defined outreach activities to support of community-based outreach initiatives.

Since January 2001 through October 2001, the KCHIP Website has been accessed 3,870 times per month on average. Total KCHIP hotline calls during the same ten-month period were 16,815 for a monthly average of 1,401. For the same timeframe 20,501 applications were received at the KCHIP Post Office Box for a monthly average of 1,708.

A second annual Awards of Excellence Banquet was held to recognize outstanding efforts of workers and their organizations in promoting KCHIP. The banquet was sponsored by the Robert Wood Johnson Foundation's "Covering Kids" Grants in cooperation with KCHIP.

Barriers: One barrier is educating parents about the importance of establishing a medical home; being sure that children receive appropriate preventive and primary care; and navigating the health care system effectively.

C. Enrollment

Successes: Enrollment in KCHIP has far surpassed Kentucky's original goals. Total cumulative enrollment of 85,264 in September 2001 exceeds the original estimate of 78,000. For the past three years both the Back-to-School Campaign and outreach efforts through the State Fair have been successful in enrolling children. The success of our Back-to-School Campaign is attributable to our partners: the State Department of Education, the Family Resources and Youth Services Centers and the local schools.

D. Retention/disenrollment

Successes: Respondents of the KCHIP Recertification Survey report overall satisfaction with the health care services they had received while in KCHIP, rating their child's KCHIP healthcare "8.42" on a scale from 0 (worst possible) to 10 (best possible). At the time of the survey (four to eight months after those surveyed had allowed their KCHIP status to lapse), 57% reported they had already re-enrolled in KCHIP or Medicaid and 76% of the respondents plan to sign up their child for KCHIP in the future.

Barriers: A large portion of families choose not to recertify with either a mail-in process or a face-to-face process. According to the KCHIP Recertification Survey SFY01, 42% of the respondents did not try to recertify, primarily, because they believed they were no longer eligible, due to changes in income and the child reaching age 19. Many of these individuals did eventually try to recertify and did become eligible for KCHIP or Medicaid.

E. Benefit structure

No change. The benefit package for the separate insurance program is the same as Medicaid's except it does not include non-emergency transportation and EPSDT Special Services.

F. Cost-sharing

Kentucky has not implemented cost sharing.

G. Delivery system

Successes. 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.

H. Coordination with other programs

Successes. Kids NOW, a landmark comprehensive early childhood legislation enacted during the 2000 legislative session, is beginning to impact children's health statewide. The program includes: folic acid campaign; substance abuse treatment program for pregnant and post-partum women; Universal Newborn Hearing Screening; Immunization Program for Underinsured Children; Mandatory Eye Examination for children entering Head Start, preschool or public schools; and an assortment of programs and initiatives to support families, enhance early care and education, and to establish early childhood support. (For more information on KIDS NOW, see Appendix F.)

In addition to KIDS NOW, the Department for Medicaid Services continues to work with local health departments, local schools, and the family resource youth service centers as well as many other state and community partners to promote on-going and successful outreach efforts.

I. Crowd-out

Kentucky uses a six-month waiting period to control for crowd-out.

J. Other

SECTION 4: PROGRAM FINANCING

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

- 4.1 Please complete Table 4.1 to provide your budget for FFY 2001, 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 2001 starts 10/1/00 and ends 9/30/01).

	FFY 2001 Costs	FFY 2002 Budget	FFY 2003
Benefit Costs			
Insurance payments			
Managed care	13,317,530	18,690,519	19,359,236
per member/per month rate X # of eligibles		144.78	149.96
Fee for Service	69,598,518	82,388,381	86,530,064
Total Benefit Costs	82,916,048	101,078,900	105,889,300
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	82,916,048	101,078,900	105,889,300
Administration Costs			
Personnel	707,907	960,013	968,521
General administration	75,111	101,860	102,762
Contractors/Brokers (e.g., enrollment contractors)	2,162,500	2,932,627	2,958,616
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	2,945,518	3,994,500	4,029,900
10% Administrative Cost Ceiling	8,291,605	10,107,890	10,588,930
Federal Share (multiplied by enhanced FMAP rate)	68,062,463	82,965,957	86,748,233
State Share	17,799,103	22,107,443	23,170,967
TOTAL PROGRAM COSTS	85,861,566	105,073,400	109,919,200

- 4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

Not applicable.

- 4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

- 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.

No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

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

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

Table 5.1	Medicaid expansion SCHIP program	Separate SCHIP program
Program Name	KCHIP Phase I and 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 Department 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 (Department 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)
Average length of stay on program	Specify months <u>6.3</u>	Specify months <u>6.5</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
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> This will no longer apply to the Medicaid Expansion Program when the new contract goes into effective- July 2002.	<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

Table 5.1	Medicaid expansion SCHIP program	Separate SCHIP program
		health benefits, expiration of COBRA, self-employment, and termination of health benefits due to long term disability.
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 coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information precompleted and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed

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

To initially apply for KCHIP/Medicaid the applicant completes the simplified two-page, mail-in application, attaches documentation of income and child care expenses, and mails it in the self-addressed stamped envelop. These applications are sorted at the post office box by county of residence and mailed to the Department for Community Based Services (DCBS) local county office for eligibility determination. Applications can also be mailed or delivered to the local DCBS county office where the applicant lives. The application is approved within 30 days if all pertinent information is included in the mail-in application.

For KCHIP/Medicaid recertification, a face-to-face interview is conducted at the DCBS office in the client's county of residence. Families receive a recertification notice from DCBS with a scheduled appointment for an interview and instructions on what documents to bring. Clients must keep the appointment or call the DCBS office at least one day in advance of the interview to reschedule. A discontinuance notice is sent to the recipient if the appointment is missed without being rescheduled. The recipient is given 10 business days from the date on the notice to respond, after which the recipient will need to *reapply* rather than recertify. At the interview the person, if still eligible, is renewed for KCHIP/Medicaid and screened for any other services he may be eligible to receive. All Family Related and AFDC

Related Medicaid and KCHIP reapplications (in which prior coverage was discontinued due to failure to meet the annual recertification requirements within the prior 12-month period) are scheduled for a face-to-face interview to complete the reapplication process.

SECTION 6: INCOME ELIGIBILITY

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

- 6.1 As of September 30, 2001, 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 17**

Medicaid SCHIP Expansion

**100% of FPL for children aged 18
150% of FPL for children aged 1 through 18**

Separate SCHIP Program

200% of FPL for children aged birth through 18

- 6.2 As of September 30, 2001, 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 "NA".*

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 under age 14, and for children 14 and over if care is necessary for the safety of the child. The maximum deduction for children under age 2 is \$200. The deduction for children over age 2 is \$150 for parent/s 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 at 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	Separate SCHIP Program
Earnings	\$ 90	\$ 90	\$ 90
Self-employment expenses	\$ Varies	\$ Varies	\$ Varies
Alimony payments Received	\$ NA	\$ NA	\$ NA
Paid	\$ NA	\$ NA	\$ NA
Child support payments Received	\$ 50	\$ 50	\$ 50
Paid - <i>Deduction is what is paid</i>	\$ NA	\$ NA	\$ NA
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)	\$ NA	\$ NA	\$ NA

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

Title XIX Poverty-related Groups

No ___ Yes, specify countable or allowable level of asset test _____

Medicaid SCHIP Expansion program

No ___ Yes, specify countable or allowable level of asset test _____

Separate SCHIP program

No ___ Yes, specify countable or allowable level of asset test _____

Other SCHIP program _____

No ___ Yes, specify countable or allowable level of asset test _____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ 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 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage

B. Employer sponsored insurance buy-in

C. 1115 waiver

D. Eligibility including presumptive and continuous eligibility

Presumptive eligibility for children is being explored.

E. Outreach

Future directions will shift to retention efforts; to improving children's health by assuring that every child has a medical home and receives appropriate preventive and primary care; and that parents are educated on the effective use of the health care delivery system.

F. Enrollment/redetermination process

G. Contracting

H. Other

We are continuing to explore cost sharing for the separate insurance program.