



## HEALTH INSURANCE PROGRAM

This section highlights the key accomplishments of Kentucky Children's Health Insurance Program (KCHIP) toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the KCHIP program, as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in the sections that follow.

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

The Kentucky Cabinet for Health Services used data developed by the Kentucky Legislative Research Commission (LRC) to estimate the number of uninsured children in Kentucky. These estimates were based on the Kentucky Health Insurance Survey in 1996 and 1997 and the Current Population March Supplement Survey estimates for the same years. Based on these sources, LRC estimated in 1997 there were 154,000 uninsured children in the state, 123,000 of whom were under 200% of the Federal Poverty Level (FPL). Of those children, 45,000 (approximately 30%) are believed to meet current Medicaid eligibility requirements, but have not enrolled in Medicaid. An additional 23,000 children age 14 through 18 are between 33% and 100% FPL, and another 35,000 children age one through 18 are between 100% and 150% FPL. These two groups of children have been targeted for enrollment in a Title XXI Medicaid expansion through the Kentucky Children's Health Insurance Program (KCHIP) in the first two phases of implementation. The remaining 20,000 children whose families have incomes between 150% and 200% FPL are covered in the third phase of implementation in a state designed health insurance program with a starting date of November 1, 1999. These baseline estimates were included in Kentucky's initial SCHIP State Plan that was submitted on June 10, 1998.

The Legislative Research Commission has recently updated the "Status of the Health Insurance Market in Kentucky" to reflect 1998 Kentucky Health Insurance Survey data. It is important to note that the survey was conducted before KCHIP implementation. The updated report indicated that approximately 139,000, or 13.7%, of Kentucky children are without health insurance. There are approximately 63,000 (45%) children below 100% FPL, 33,000 (24%) children between 101% to 150% FPL, and 15,000 (11%) children between 151% to 200% FPL. The range of this estimate, with a confidence level of 95%, falls between 127,000 and 150,000. About 111,000 of these children have family incomes that would qualify them for traditional Medicaid or KCHIP. Although this figure reflects an apparent decrease from the previous estimate of 123,000 eligible children, this decrease is not statistically significant. Again, any decrease that might be construed from these data cannot be attributed to KCHIP because the survey was conducted before KCHIP implementation. (Source: Michael Clark: Status of the Health Insurance Market in

**Kentucky, 1998, Frankfort, KY: Legislative Research Commission, February, 2000.)**

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

**The Kentucky Legislative Research Commission (LRC) has studied the insurance status of the state for the past three years. Data for these reports were collected in three annual Kentucky Health Insurance Surveys in 1996, 1997 and 1998 (telephone surveys), and were combined with data from the March Supplement to the annual Current Population Survey. The March 1999 CPS sample includes 659 Kentucky households, with 1,652 individuals. The 1998 Kentucky Health Insurance Survey was conducted in two phases: 1) randomly interviewing households regarding their health insurance, and 2) over-sampling selected segments of the health insurance market – uninsured, government insured, large-group insured, small-group insured, group insured (no data on group size), and individually insured. The initial phase interviewed 1,326 households with an overall margin of error for estimates at plus or minus 2.7%. The second phase included a sample of 3,743 households, and the uninsured sample size was 739 households.**

**Because the sample size of children was fairly small for any one year, data for 1997 through 1999 were combined to increase the sample size. The advantage of this 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. However, as all the survey data precede KCHIP implementation, this technique allows us to determine a more meaningful and accurate baseline against which to assess the impact of KCHIP over the long term.**

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

**As noted, these estimates are the most reliable available estimates, and provide some detail regarding family income level and age of the children. Even so, the relatively small sample size does not yield data adequate to assess the number of uninsured, KCHIP-eligible children at a geographic level other than statewide, or to determine with specificity why they are uninsured. When parents were asked why their children had no health insurance, while cost was a criterion for 19%, the largest proportion of responses is noted as “Other” (39%). The standard error range for the survey as a whole is as noted above, plus or minus 2.7%, and would presumably be larger for the data on children, although no range is given.**

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

*implementation of Title XXI? (Section 2108(b)(1)(A))*

**Phase I of KCHIP was implemented on July 1, 1998, for children from 14 to 19 years of age in families up to 100% FPL. As of September 30, 1999 9,071\* teens had been enrolled in this Medicaid expansion. KCHIP's Phase II for children from age 1 to 19 in families at 150% FPL enrolled 9,856\* in the three months from its inception on July 1, 1999 to September 30, 1999. Because KCHIP requires that children be voluntarily without health insurance for at least six months as a condition of eligibility, we can state with certainty that these children were previously uninsured; thus, their enrollment represents an addition to the number of children with creditable coverage. Also, it is estimated that an additional 16,080 children enrolled in Medicaid during the quarter July 1, 1999, through September 30, 1999. (\*Note – Data used in this section of the report were taken from an ad hoc report run on 01/20/00 using Kentucky Department for Medicaid Services' Management Information System, and it represents cumulative data on total number of recipients ever enrolled in the KCHIP Program from its inception on 07/01/98.)**

**The real story does not rest with the aggregate State numbers, but it is in the difference it is making in the lives of the children and their families who now have creditable coverage.**

**As Pia Cummings, a mother, stated in a KCHIP training video which she narrates,**

**“What do I worry about as a parent? I know one of my biggest worries is my daughter's well-being. If she is healthy the rest we can deal with. Last year for several months, we were without health insurance – and I really felt we were living on borrowed time. I was constantly worried – what if my daughter breaks her arm, or was in a car accident, or just got really sick – how would I pay for that with no health insurance? It's a frightening position to be in.”**

**A copy of a video training tape, “Building Healthy Families,” is being sent with this report. The video tape provides short interviews with families who have enrolled their children in KCHIP. It is used to train outreach workers and inform employers of the importance families place on having access to health insurance for their children.**

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

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

**These data are derived directly from eligibility determinations entered into Kentucky's automated data system, and may reflect erroneous determinations or erroneous data entry, but are otherwise very reliable. Current month figures are subject to adjustments in subsequent months to account for retroactive eligibility; thus, the enrollment data can only**

**be stable after approximately four months have passed.**

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

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

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

Column 2: Lists the performance goals for each strategic objective.

Column 3: For each performance goal, an indication on how performance is being measured, and progress towards meeting the goal is provided. As appropriate, specific data sources, methodology, and measurement approaches (e.g., numerator, denominator) are listed

For each performance goal specified in Table 1.3, additional narrative is provided discussing how actual performance to date compares against performance goals. and findings to date. If performance goals have not been met, a discussion of the barriers or constraints is provided. The narrative also provides a discussion of future performance measurement activities, including a projection of when additional data are likely to be available.

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Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
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**OBJECTIVES RELATED TO CHIP ENROLLMENT**

**Within two years  
increase numbers of  
children with  
creditable coverage**

- 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:

- Medicaid and KCHIP enrollment data
- KY Legislative Research Commission (LRC) annual insurance studies.

Methodology:

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: *(Note: Data used in this section of the report were taken from an ad hoc report run on 01/20/00 using Kentucky Department for Medicaid Services' Management Information System, and it represents cumulative data on total number of recipients ever enrolled in the KCHIP Program from its inception on 07/01/98.)*

- September 30, 1999, 18,927 children had ever been enrolled in the KCHIP program; i.e., 9,071 in Phase I and 9,856 in Phase II.
- December 31, 1999 31,783 children had ever been enrolled in the KCHIP Program; i.e., 9,698 in Phase I, 18,776 in Phase II, and 3,309 in Phase III.
- Performance Goal for Phase I was ahead of projection and was achieved in

Table 1.3

January, 2000 . Performance Goal for Phase II was achieved in December, 1999, which is six months ahead of projection.

**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:

- Departmental administrative data, Medicaid Eligibility System Report.

Methodology: Compare the average number of children newly enrolled in Program Code I for SFY99 and SFY 00

Progress Summary: Average monthly enrollment increase from July 1, 1999 to September 30, 1999 was approximately 5,360.

**OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)**

Table 1.3

**Within three years increase health status of children.**

- 90% of children covered under KCHIP will have complete immunizations by age 2,
- 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,
- 50% of children will receive a comprehensive eye exam by an eye care specialist between age 3-6.

Data Sources:

- Hedis 3.0
- Administrative Data

Methodology:

Numerator:

Denominator:

Progress Summary:

- Data are not yet available for these indicators.
- Due to a shift in Kentucky’s managed care strategy the availability of Hedis data will need to be re-assessed.

Table 1.3

## OTHER OBJECTIVES

<p><b>1. Within two years reduce barriers to affordable health coverage</b></p>	<p>1. Cost sharing will be at a level that families will enroll in KCHIP with at least 30,000 participants</p>	<p>Data Sources:</p> <ol style="list-style-type: none"> <li>1. Not applicable at this time.</li> <li>2. KCHIP Annual Report for Federal Fiscal Year 1998 to HCFA</li> </ol>
<p><b>2. Within one year of HCFA plan approval, provide statewide coverage</b></p>	<p>2. Provide statewide coverage with KCHIP through APO contract or state run program</p>	<p>Progress Summary:</p> <ol style="list-style-type: none"> <li>1. Cost sharing is included in the approved plan, but has not yet been implemented.</li> <li>2. KCHIP program has been changed to include a Phase III which is a Medicaid look alike. KCHIP was fully implemented to 200% FPL in November, 1999, and this performance goal was met within the targeted time frame.</li> </ol>

## **Assessment of Strategic Objectives and Related Performance Goals and Measures**

The following objectives are stated in the KCHIP state plan as amended and approved on September 3, 1999. The objectives have been developed in conjunction with “Healthy Kentuckians 2000”, Kentucky’s responses to “National Health Promotion and Disease Prevention Objectives”. For each objective listed in the prior table, there is narrative discussion that includes: performance measures, progress toward goals, barriers to meeting goals and future plans regarding progress.

### **Objective 1:**

Within two years, increase numbers of kids with creditable coverage

#### **Performance Measures:**

- KCHIP, including the Medicaid expansion and Medicaid outreach, will cover approximately 50,000 additional children;
- KCHIP’s separate insurance program will achieve 50% penetration and enroll 10,000 children (KCHIP Phase III implementation date 11/1/99). The Medicaid expansion will enroll approximately 27,500 additional children (KCHIP Phase I implementation date 7/1/98 & Phase II implementation date 7/1/99). Improved outreach will enroll approximately 10,000 children currently Medicaid eligible. *(See Appendix for targeted number of children to be enrolled by each phase in the first three years of the program. Data used in this section of the report were taken from an ad hoc report run on 01/20/00 using Kentucky Department for Medicaid Services’ Management Information System, and it represents cumulative data on total number of recipients ever enrolled in the KCHIP Program from its inception on 07/01/98.)*

#### **Progress:**

The number of children enrolled in KCHIP as of September 30, 1998 was 2,880, and the number enrolled as of September 30, 1999 was 18,927. The number enrolled through the end of the following quarter, December 31, 1999 was 31,783. This exceeds the estimated projected number to be enrolled at this point in the amended plan. It was projected that this enrollment figure would be attained by June 30, 2000. Success is attributed to the extensive and aggressive outreach conducted at the state and local level, to the simplified mail-in application for KCHIP and Medicaid children implemented on July 1, 1999, to the high level priority placed on enrolling uninsured children by Governor Patton and the Kentucky legislators, and to the importance health insurance coverage has for Kentucky families.

The **KCHIP Phase I**, a Medicaid expansion, for children, ages 14-19, in families at or below 100% FPL (\$16,700 a year for a family of four) 2,880 children had ever been enrolled on

September 30, 1998, and 9,071 had ever been enrolled on September 30, 1999. It was estimated that 10,000 youth would be enrolled after two years of operation. The total number of estimated eligible children is 23,000. After 15 months of operation the goal for enrolling 10,000 teens is approaching achievement.

**KCHIP Phase II** began on July 1, 1999. Medicaid was expanded to cover eligible children from one through 18 years of age who did not already have health insurance and whose family income fell at or below 150% FPL (\$25,050 a year for a family of four). It is estimated that there may be 35,000 children in this category. In the first quarter of operation, July 1, 1999 to September 30, 1999, there were 9,856 children ever enrolled. In the first year, it was estimated that 50% of the estimated number of eligible children would be enrolled. After 3 months of operation, the outreach efforts had exceeded expectations and had achieved over half of the enrollment goal for the first year.

The Kentucky Department for Medicaid Services has collaborated with various agencies and organizations to reach as many children as possible in need of health insurance coverage through ongoing outreach efforts. Local public health departments have coordinated the local outreach. Family Resource and Youth Services Centers which are located at many of the public schools, Community Action Agencies, and The Department for Community Based Services have also been key partners to successful outreach. The University of Kentucky received a Robert Wood Johnson Covering Kids Grant and the communities of Harlan and Murray were contracted by HCFA to develop innovative local outreach strategies, and the Covering Kids grant is an essential element of building collaborative partnerships for KCHIP outreach. Other active partners include the KCHIP Advisory Council's workgroup on outreach, children's advocacy groups and the Department of Education.

The following methodology is used in this report to derive the numbers of children who have been enrolled in each of the identified phases of KCHIP. KCHIP children are flagged within Medicaid eligibility systems with KCHIP recipient status codes, enrollment and financial reports are generated based on these status codes.

### **Barriers:**

There have been two barriers that have required on going problem solving and adjustments to the implementation of the program, and they are: 1) limited development time vs. the urgency to make insurance program available to uninsured children, and 2) lack of outreach dollars in the initial stages of program development and implementation.

The original state plan called for developing a separate insurance program that would involve contracting for health services through Accountable Pediatric Organizations or managed care organizations; however, it became apparent that the development time, where statewide access could be assured, would require more time than was acceptable. As a result, Kentucky amended its plan to enlarge its Medicaid expansion, and Phase II of KCHIP was implemented on July 1, 1999 for children from one to 19 in families at or below 150% FPL. In November, 1999, Phase

III was implemented as a state designed insurance program that is described as a Medicaid look-alike for children from birth to 19 in families from 150% to 200% FPL. The willingness of the administration to be flexible in the approach to KCHIP implementation has enabled 31,783 children to be enrolled in KCHIP in the first year and a half of operation.

The lack of funding for outreach in the initial months of KCHIP was a barrier to making recipients and their families aware of the new program. There have been three opportunities that have helped overcome the lack of funding. The University of Kentucky received a Robert Wood Johnson Covering Kids grant for KCHIP outreach which has promoted collaboration and innovation. Second, the KCHIP Advisory Council, which is appointed by the Governor, established an outreach workgroup that has been exceptionally proactive by developing plans and supporting outreach initiatives. Also, access to funds from the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 for simplifying the Medicaid eligibility systems and conducting outreach related to the implementation of Section 1931 of the Social Security Act aided in the overall outreach efforts.

**Future Plans:**

Future plans call for continuing aggressive outreach initiatives, assessing the re-certification process and reasons for disenrollment, and fine-tuning the current program to address several policy issues including substitution of KCHIP coverage for private health insurance and family cost-sharing.

**Objective 2:**

Within two years, increase Medicaid enrollment

**Performance Measures:**

- An additional 10,000 currently Medicaid eligible children will be enrolled in Medicaid.

**Progress:**

It is estimated that an increased 16,080 children enrolled in Medicaid during the quarter July 1, 1999, through September 30, 1999 as compared to the previous year. This increase is attributed to the simplified mail-in application and intensive KCHIP outreach. This estimated number is based on the monthly number of newly enrolled children in Medicaid who are identified in enrollment data under Program Code "I". Program code "I" is the Medicaid eligibility category where children who apply on the mail-in applications are counted. This does not account for children in other program codes. There was no mail-in application prior to July 1, 1999.

**Future Plans:**

The simplified mail-in application has been viewed as a successful approach to determining eligibility. Currently, a workgroup has been established to evaluate other eligibility simplification strategies and assess the possibility of simplifying the re-certification process.

### **Objective 3:**

Within three years, increase the health status of children

#### **Performance Measures:**

- 90% of children covered under KCHIP will have complete immunizations by age 2;
- 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; and
- 50% of children will receive an eye exam by an eye care specialist between age 3-6.

#### **Progress:**

Data will be available through health care partnerships, statewide immunization rates, other managed care organizations, and administrative data within the three year projected time frame; however, the KCHIP program is too new to have produced this data.

#### **Barriers:**

KCHIP has changed its approach from using the Accountable Pediatric Organizations (APOs) to using the Kentucky Department for Medicaid Services' health care delivery system which is currently being restructured. The original plans called for the managed care organizations to track this data; however, the changes occurring in the health care delivery system will require adjustments to be made in collecting and tracking data on these performance measures. Tracking data on immunizations has been particularly difficult and complex.

#### **Future Plans:**

KCHIP is working with the Division for Quality Improvement to develop a comprehensive and coordinated plan within the Department for Medicaid Services to provide better data for preventive care objectives. The first quarterly report on KCHIP encounter data from a managed care partnership region will be for January –March, 2000.

## SECTION 2. BACKGROUND

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

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

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

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

Name of program: **KCHIP Phase I and KCHIP Phase II**

Date enrollment began (i.e., when children first became eligible to receive services): **KCHIP Phase I, July 1, 1998**  
**KCHIP Phase II, July 1, 1999**

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

Name of program: **KCHIP Phase III**

Date enrollment began (i.e., when children first became eligible to receive services): **KCHIP Phase III, November 1, 1999** (*Phase III did not begin until after the reporting period; however, information has been included regarding the state designed CHIP program in the narrative when appropriate.*)

Other - Family Coverage

Name of program: \_\_\_\_\_

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

Other - Employer-sponsored Insurance Coverage

Name of program: \_\_\_\_\_

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

\_\_\_ Other - Wraparound Benefit Package

Name of program: \_\_\_\_\_

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

\_\_\_ Other (specify) \_\_\_\_\_

Name of program: \_\_\_\_\_

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

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

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

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

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

**Kentucky's original plan for KCHIP was to develop a state designed health insurance program with premiums and co-payments for children up to 200% FPL and to provide a Medicaid expansion for children 14-19 up to 100% FPL. Care was to be provided through a managed care system. This plan was changed because of problems in attracting bidders, the length of time needed to implement the complex program, and the mandate to have KCHIP services available statewide within one year of approval of Kentucky's initial Title XXI plan.**

**Kentucky's managed care system for Medicaid has significantly affected the KCHIP design. Kentucky began the Medicaid managed care partnership program in 1997 with a goal of having eight regional partnerships to care for the state's Medicaid recipients. On December 15, 1999, Cabinet for Health Services Secretary Jimmy Helton announced major changes to the managed care program in Kentucky. The changes mean that health maintenance organizations can seek a contract through competitive bidding to cover Medicaid recipients in a single county or across the state. Another option, known as a Primary Care Case Management system, will also be offered to recipients statewide. This system of care is known as the Kentucky Patient Access and Care System (KenPAC).**

**Kentucky's KCHIP plan was amended in August, 1999, to include a Medicaid expansion for children from 1 to 19 in families up to 150% FPL. This has been referred to as KCHIP Phase II and was implemented on July 1, 1999. On November 1, 1999, a KCHIP Phase III roll out was implemented for children from birth to 19 for children in families up to 200% FPL. KCHIP Phase III is a state designed insurance program and can best be described as a Medicaid look alike. It provides services through the Medicaid infrastructure, but it does not include non-emergency transportation or EPSDT special services in the benefit package.**

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

**No** pre-existing programs were "State-only"

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

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

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

Changes to the Medicaid program

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

Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF  
(specify) \_\_\_\_\_

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

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

Changes in the delivery system

- Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- Changes in hospital marketplace (e.g., closure, conversion, merger)
- Other (specify) \_\_\_\_\_

\_\_\_ Development of new health care programs or services for targeted low-income children (specify)  
\_\_\_\_\_

\_\_\_ Changes in the demographic or socioeconomic context

\_\_\_ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)  
\_\_\_\_\_

\_\_\_ Changes in economic circumstances, such as unemployment rate (specify)\_\_\_\_\_

\_\_\_ Other (specify)\_\_\_\_\_

\_\_\_ Other (specify)\_\_\_\_\_

**Narrative Comments:**

**The Kentucky Long-Term Policy Research Center in cooperation with the University of Kentucky's Center for Health Services Management and Research published, "What Next for Kentucky Health Care?" in 1999. In the publication it was stated that recent analyses of state insurance reform initiatives suggest that Kentucky's experience represents a familiar pattern, although our individual health insurance market has been more unstable than most. Kentucky's 1994 health care legislation attempted to increase the number of insured Kentuckians without adding to the state's tax burden. More recent legislative initiatives have attempted to shore up what was perceived as a dangerously impaired commercial health insurance market. The only real shift in the legislative emphasis away from the private sector has been to benefit the Commonwealth's children through the implementation of KCHIP. (page 23)**

**There has been concern with welfare reform that children do not lose access to health coverage. In a preliminary report on the impact of welfare reform in the Commonwealth of Kentucky by the Urban Studies Institute, University of Louisville, 1999, it was reported that over 90% of respondents in a panel study with a sample of 715 cases stated their child's health was good or excellent. There was no significant difference between active versus discontinued cases. Almost all active K-TAP children were covered by a medical card; 83% of discontinued K-TAP cases were covered by a medical card, and an additional 11% had some form of medical insurance; 6% of discontinued K-TAP children had no medical insurance coverage.**

## SECTION 3. PROGRAM DESIGN

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This section describes the elements of Kentucky’s State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

### 3.1 Who is eligible?

*3.1.1 The standards used to determine eligibility of targeted low-income children for child health assistance under the plan are described in the following table. For each standard, the criteria used to apply the standard is described. If not applicable, “NA” is entered.*

<b>Table 3.1.1</b>			
	<b>Medicaid CHIP Expansion Program - Phase I</b>	<b>Medicaid CHIP Expansion Program – Phase II</b>	<b>State-designed CHIP Program Phase III</b> <i>(Not implemented during the reporting period)</i>
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide	Statewide	
Age	14-18 years	1-18 years	
Income (define countable income)	0-100% FPL	100-150% FPL	
Resources (including any standards relating to spend downs and disposition of resources)	NA	NA	
Residency requirements	Must be State resident	Must be State resident	
Disability status	NA	NA	

03/30/00

Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	NA	May not voluntarily drop insurance for six months prior to application	
Other standards (identify and describe)	NA	NA	

### Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999**. Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to. Name \_\_\_\_\_, phone/email \_\_\_\_\_

*3.1.1.1 For each program, do you use a gross income test or a net income test or both?*

Title XIX Child Poverty-related Groups	<u>  X  </u> Gross	___ Net	___ Both
Title XXI Medicaid SCHIP Expansion	<u>  X  </u> Gross	___ Net	___ Both
Title XXI State-Designed SCHIP Prog	___ Gross	___ Net	___ Both
Other SCHIP program _____	___ Gross	___ Net	___ Both

*3.1.1.2 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.*

Title XIX Child Poverty-related Groups

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 13  

Title XXI Medicaid SCHIP Expansion

100 % of FPL for children aged  14 through 18  

150 % of FPL for children aged   1 through 18

\_\_\_\_% of FPL for children aged \_\_\_\_\_  
 Title XXI State-Designed SCHIP Program  
 \_\_\_\_% of FPL for children aged \_\_\_\_\_  
 \_\_\_\_% of FPL for children aged \_\_\_\_\_  
 \_\_\_\_% of FPL for children aged \_\_\_\_\_  
 Other SCHIP program \_\_\_\_\_  
 \_\_\_\_% of FPL for children aged \_\_\_\_\_  
 \_\_\_\_% of FPL for children aged \_\_\_\_\_  
 \_\_\_\_% of FPL for children aged \_\_\_\_\_

*3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)*

*Enter “Y” for yes, “N” for no, or “D” if it depends on the individual circumstances of the case.*

<b>Table 3.1.1.3</b>				
	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Family Composition				
Child, siblings, and legally responsible adults living in the household	D	D		
All relatives living in the household	N	N		
All individuals living in the household	N	N		
Other (specify)				

3.1.1.4 *How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.*

*Enter “C” for counted, “NC” for not counted and “NR” for not recorded.*

<b>Table 3.1.1.4</b>				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings of dependent children	C	C		
Earnings of students	NC	NC		
Earnings from job placement programs	NC	NC		
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC	NC		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC		
Education Related Income Income from college work-study programs	NC	NC		
Assistance from programs administered by the Department of Education	Depends on intended purpose	Depends on intended purpose		
Education loans and awards	NC	NC		
Other Income Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received	C	C		

Roomer/boarder income	C	C		
Income from individual development accounts	NC	NC		
Gifts	NC	NC		
In-kind income	NC	NC		
Program Benefits Welfare cash benefits (TANF)	C	C		
Supplemental Security Income (SSI) cash benefits	C	C		
Social Security cash benefits	C	C		
Housing subsidies	C	C		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	NC	NC		
Low income energy assistance payments	NC	NC		
Native American tribal benefits	NC	NC		
Other Types of Income (specify) Any type of pensions, annuity, interest earned & unearned	C	C		

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

3.1.1.5 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.”**

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) \_\_\_\_ Yes \_\_\_\_ X  
No

If yes, please report rules for applicants (initial enrollment).

<b>Table 3.1.1.5</b>				
Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	\$90	\$90		\$
Self-employment expenses – <i>Losses, depreciation, taxes</i>	Depends	Depends		\$
Alimony payments Received	NA	NA		\$
Paid	NA	NA		\$
Child support payments Received	NA	NA		\$
Paid – <i>Deduction is what is paid.</i>	Depends	Depends		\$
Child care expenses	Up to \$200	Up to \$200		\$
Medical care expenses – <i>Only if aged, blind or disabled</i>	NA	NA		\$
Gifts	NA	NA		\$
Other types of disregards/deductions (specify)	\$	\$		\$

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

right click on the mouse, select “insert” and choose “column”.

*3.1.1.6 For each program, do you use an asset or resource test?*

Title XIX Poverty-related Groups

No                       Yes (complete column A in 3.1.1.7)

Title XXI SCHIP Expansion program

No                       Yes (complete column B in 3.1.1.7)

Title XXI State-Designed SCHIP program

No                       Yes (complete column C in 3.1.1.7)

Other SCHIP program \_\_\_\_\_

No                       Yes (complete column D in 3.1.1.7)

*3.1.1.7 How do you treat assets/resources?*

***Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter “NA.”***

<b>Table 3.1.1.7</b> Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State-designed SCHIP Program (C)	Other SCHIP Program* <u>(D)</u>
Countable or allowable level of asset/resource test	NA	NA		\$
Treatment of vehicles: Are one or more vehicles disregarded? <i>Yes or No</i>	NA	NA		
What is the value of the disregard for vehicles?	NA	NA		\$
When the value exceeds the limit, is the child ineligible (“I”) or is the excess applied (“A”) to the threshold allowable amount for other assets? ( <i>Enter I or A</i> )	NA	NA		

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

3.1.1.8 *Have any of the eligibility rules changed since September 30, 1999?*        X   No

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

3.1.2 How often is eligibility redetermined?

<b>Table 3.1.2</b>			
<b>Redetermination</b>	<b>Medicaid CHIP Expansion Program Phase I</b>	<b>Medicaid CHIP Expansion Program Phase II</b>	<b>State-designed CHIP Program Phase III</b>
Monthly			
Every six months			
Every twelve months	Yes	Yes	
Other (specify)			

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

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

Yes <sup>o</sup>

Which program(s)?

**If a recipient lives in a region of the State covered by a managed care partnership, continuous eligibility is provided for 6 months. There are two managed care regions operating in the more populated areas of the state involving approximately 1/3 the recipients.**

For how long?

**Six months in managed care partnerships**

No

**For most recipients, changes in eligibility status must be reported to a case worker within 10 days. This would include reporting changes in number of hours worked, pay per hour, getting a new kind of income, losing income, anyone related to the KCHIP child moving in or out of the home, etc. Changes in income could result in loss of KCHIP if you earn more than the guidelines allow, or the child may become eligible for regular Medicaid if**

**there has been a loss of income.**

3.1.4 *Does the CHIP program provide retroactive eligibility?*

Yes

*Which program(s)?*

**All phases of the program; i.e., Medicaid expansion and State designed program**

*How many months look-back?*

**If the applicant lives in a region with Medicaid managed care, eligibility dates back to the first day of the month that the application is received. If the applicant lives in a region not under Medicaid Managed Care, then eligibility may extend back to three months to cover those expenses.**

3.1.5 *Does the CHIP program have presumptive eligibility?*

Yes

*Which program(s)?*

**Kentucky's Title XXI approved plan allows for the implementation of presumptive eligibility and is currently evaluating it.**

*Which populations?*

**All potentially eligible targeted low income children who are residents.**

*Who determines?*

**A qualified entity for presumptive eligibility in Kentucky is a provider, organization or institution that provides health care related services. Providers must be certified by Dept. for Medicaid Services and enrolled in the Medicaid Provider program and would include primary care providers, hospitals, health departments and primary care centers. To become a qualified entity, a provider must volunteer to participate and complete training.**

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

Yes

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

No

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

**Kentucky's eligibility determination process allows an applicant to complete a two page application with one month of income and child care expenses verification. Local public health departments, and many other health and human services agencies and health providers assist families to complete the application. Assistance is also available through a toll free line. The application is mailed to the local Department for Community Based Services whose staff is responsible for eligibility determination.**

***Strengths* of the eligibility determination process fall into four areas: 1) simplification of the process and the application; 2) reduced stigma; 3) convenience for the applicant; and 4) more efficient processing by staff due to fewer face-to-face appointments. Using a two page, mail-in application and reducing income verification to only one month, has been a significant and welcome change from past process. Subjective evaluations by staff have indicated that it is working effectively.**

***Weaknesses* of the eligibility determination process can be categorized in two areas: 1) incomplete data due to incomplete information provided on the application; and 2) reduced understanding of benefits and service access to KCHIP and other available support programs. In face-to-face interviews information can be customized to meet the applicant's needs and questions can be answered. It is felt that adjustments and changes can be made to improve the mail-in process. Discussions are already taking place to avoid problems associated with incomplete applications that include listing reminders on the mail in envelope of "must dos."**

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

**The re-certification process currently requires that a family member or close associate of the insured child make a face-to-face appointment with a case worker at the local Department for Community Based Services office every twelve months. It is estimated that the face-to-face interview would last approximately one hour.**

The *strengths* of using this approach center on individualizing needs that can result in resolving Medical Support Enforcement issues, accessing services, answering questions, networking to other service supports, and reducing fraud.

The *weaknesses* for the applicant of using this approach focus on three areas: 1) the increased perceived stigma related to welfare; 2) increased time and transportation issues related to going to an office during regular working hours; and 3) assumption that families need help navigating the system. There is also a complicating problem for the case workers and that is time management required to conduct face-to-face scheduled interviews. The reality is that it would require more workers to conduct face-to-face interviews, and many of the benefits of interviews can be handled through phone conversations.

A workgroup has been meeting to assess the re-certification process.

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

3.2.1 *Benefits*

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

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

<b>Table 3.2.1 CHIP Program Type Medicaid Expansion – Phase I and Phase II*</b>			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify) <b>Not Applicable</b>	Benefit Limits (Specify) – <b>All benefits must be provided by Medicaid provider network. Benefits are limited to medically necessary services; primary care provider referrals are required for some services provided through managed care.</b>
Inpatient hospital services	T		Prior authorization and concurrent review. 14 days per admission. No durational limit children under 6 in disproportionate share hospitals. No durational limit for children under one (1) in any acute care hospital.
Emergency hospital services	T		None
Outpatient hospital services	T		None. Excluded: drugs, biologicals and injectables dispensed to recipients; items and services which are not reasonable and necessary and related to the diagnosis or treatment of illness or injury; occupational therapy; and routine physical examinations.
Physician services	T		None
Clinic services	T		None
Prescription drugs	T		None. Drugs contained on drug list that are prescribed by a legally authorized health care prescriber.
Over-the-counter medications	T		Limited. Drugs contained on drug list that are prescribed by a legally authorized health care prescriber.
Outpatient laboratory and radiology services	T		None. Laboratory, radiological and imaging services that are ordered by a licensed physician, oral surgeon, dentist, or person operating under legal scope of practice when provided by qualified providers.
Family planning services	T		None. Includes: Contraceptive education; medical/nursing services; prescriptions of contraceptive methods; supplies or birth-control medications; and infertility services, including diagnosis and screening services.
Inpatient mental health services	T		None. Prior authorization and concurrent review. Applies to Acute Psychiatric Hospitals and PRTF. Pre-set criteria established by Dept. for Medicaid Services.
Outpatient mental health services	T		None

Inpatient substance abuse treatment services	T		Acute phase of medical detoxification, EPSDT Special Services, or meet criteria for Impact Plus Program.
Residential substance abuse treatment services	T		EPSDT Special Services or meet criteria for Impact Plus Program.
Outpatient substance abuse treatment services	T		EPSDT Special Services or meet criteria for Impact Plus Program.
Durable medical equipment	T		Ordered by a physician who has seen the recipient within sixty (60) days prior to initial order and attests to the medical necessity.
Disposable medical supplies	T		Certificate of Medical Necessity required every 6 months or letter of medical necessity for EPSDT Special Services.
Preventive dental services	T		Limited to one (1) cleaning per twelve (12) months per recipient.
Restorative dental services	T		None
Hearing screening	T		None
Hearing aids	T		None. Hearing services, including necessary services provided by audiologists and hearing aid dealers, are covered to evaluate and treat hearing disorders.
Vision screening	T		None
Corrective lenses (including eyeglasses)	T		Limited to two (2) pairs of eyeglasses per twelve (12) months and the dispensing of all eyeglasses requires prior authorization.
Developmental assessment	T		None
Immunizations	T		None, according to age and health history.
Well-baby visits	T		None
Well-child visits	T		None
Physical therapy	T		None
Speech therapy	T		None
Occupational therapy	T		Medically necessary under EPSDT Special Services. Designated in IEP with School-Based Services.

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Physical rehabilitation services	T		Inpatient hospital services follow aforementioned guidelines.
Podiatric services	T		Excluded: treatments for flatfoot and routine foot care, including routine cutting or removal of corns or calluses and trimming of nails.
Chiropractic services	NA		
Medical transportation (emergency)	T		None



Home health services	T		Services limited to one (1) visit per day, except for nursing, which is limited to two (2) visits per day. Care plan reviewed every sixty (60) to sixty-two (62) days.
Nursing facility	T		None
ICF/MR	T		None
Hospice care	T		Medicare benefit
Private duty nursing	T		Medically necessary under EPSDT Special Services
Personal care services	T		Directly supervised by professional nurse or physical therapist at least every 2 weeks, one (1) visit per day.
Habilitative services	T		Supports for Community Living (SCL) Waiver Program for individuals with mental retardation and developmental disabilities & meets intermediate care status.
Case management/Care coordination	T		Targeted to children with special health care needs, hemophilia, MR/DD, and SED (severely emotionally disturbed).
Non-emergency transportation	T		Pre-authorized. Travel to pharmacies not covered.
Interpreter services	T		When there are language barriers.
Other (Specify)School-based Services	T		None
Other (Specify)			
Other (Specify)			

**\*The state designed CHIP Program, KCHIP Phase III, which began on November 1, 1999, is a Medicaid look-alike, and the only difference between the Medicaid look-alike and the Medicaid expansion is that non-emergency transportation and EPSDT Special Services are not covered**

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

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

**The scope and range of health coverage provided through the Medicaid Expansion Program for KCHIP can be found in Kentucky's Title XIX plan.**

3.2.3 Delivery System

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

<b>Table 3.2.3</b>			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)	Yes	Yes	
Statewide?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mandatory enrollment?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of MCOs	2 Regional		
B. Primary care case management (PCCM) program	Yes		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	No		
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Yes		
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

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

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/

copayments, or other out-of-pocket expenses paid by the family.)

**No**, skip to section 3.4n *(There are no premium requirements for the KCHIP Medicaid expansion for targeted low income children from one to 19 years of age in families up to 150% FPL. However, the approved plan includes provisions for potentially implementing family paid premiums as part of the state designed insurance program.)*

Yes, check all that apply in Table 3.3.1

<b>Table 3.3.1</b>			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

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

\*\*See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

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

- Employer
- Family
- Absent parent
- Private donations/sponsorship
- Other (specify) \_\_\_\_\_

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

- 3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?
- 3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?
- 3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

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

- 3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)
- 3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 *How do you reach and inform potential enrollees?*

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

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

<b>Table 3.4.1</b>				
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program (Combined with Medi Expans Outre)	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards	T	3.12	T	3.12
Brochures/flyers	T	4.15	T	4.15
Direct mail by State/enrollment broker/administrative contractor	T	3.84	T	3.84
Education sessions	T	3.88	T	3.88
Home visits by State/enrollment broker/administrative contractor	T	3.95	T	3.95
Hotline	T	3.56	T	3.56
Incentives for education/outreach staff	NA		NA	
Incentives for enrollees	Only provide minimal items such as pencils	3.84	T	3.84
Incentives for insurance agents	NA		NA	
Non-traditional hours for application intake	T	3.95	T	3.95
Prime-time TV advertisements/ <u>Network TV</u>	T	3.75	T	3.75
Public access cable TV/ <u>Cable TV Paid advertisements</u>	T	3.67	T	3.67
Public transportation ads	T	2.67	T	2.67
<u>Radio/newspaper/TV</u> advertisement and PSAs	T	3.69	T	3.69
Signs/posters	T	3.86	T	3.86
State/broker initiated phone calls	T	3.42	T	3.42
Other (specify) <u>One-on On</u>	T	5.00	T	5.00
Other – Community Sponsored Events	T	5.00	T	5.00
Other – Newsletter	T	5.00	T	5.00
Other – Door-to-Door visits to home and businesses	T	5.00	T	5.00

Other – Clinics	T	5.00	T	5.00
Other – Follow-up of denials	T	5.00	T	5.00
Other (specify) <u>Community Sponsored Events</u>	T	5.00	T	5.00

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

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

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

<b>Table 3.4.2</b>				
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program (Combined with Medi Expans Outre)	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters	T	2.83	T	2.83
Community sponsored events	T	4.02	T	4.02
Beneficiary's home	T	3.66	T	3.66
Day care centers	T	3.97	T	3.97
Faith communities	T	3.63	T	3.63
Fast food restaurants	T	3.75	T	3.75
Grocery stores	T	3.89	T	3.89
Homeless shelters	T	3.55	T	3.55
Job training centers	T	3.76	T	3.76
Laundromats	T	3.22	T	3.22
Libraries	T	3.35	T	3.35
Local/community health centers	T	4.42	T	4.42
Point of service/provider locations	T	3.84	T	3.84
Public meetings/health fairs	T	4.11	T	4.11
Public housing	T	3.84	T	3.84
Refugee resettlement programs	T	2.86	T	2.86
Schools	T	4.52	T	4.52
/adult education sites	T	3.47		3.47
Senior centers	T	2.76	T	2.76
Social service agency	T	3.87	T	3.87
Workplace	T	4.04	T	4.04
Other (specify)Hospitals/Government Offices	T	4.00	T	4.00
Other – Community events /food pantry	T	4.67	T	4.67
Other (specify) <u>Retail Stores</u>	T	4.67	T	4.67

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

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

**Enrollment data are tracked and monitored on a monthly basis by KCHIP staff and by the Outreach Workgroup which is an arm of the Governor appointed citizen advisory committee. Two other assessments have been conducted between December 1999 and February 2000: 1) eight focus groups of targeted low income families were held and 2) a statewide survey was sent to local outreach workers and volunteers through local public health programs. Copies of the reports from the assessments are included in appendix.**

- 3.4.4 *What communication approaches are being used to reach families of varying ethnic backgrounds?*

**Hispanic speaking families were identified as needing targeted approaches to outreach. The following approaches have been initiated. Radio and newspaper advertising has been developed in Spanish, and posters, flyers and applications have been printed and distributed in Spanish. The statewide, toll free hotline provides a Spanish speaking translator. A focus group for Hispanic speaking targeted low income families was held in January 2000 to provide more specific information on outreach. Finally, a contract has been initiated with the Kentucky Farmworker Health Program at the University of Kentucky to do targeted outreach in nineteen counties.**

**In addition to Spanish translated applications, there are applications available in Vietnamese and Bosnian. Currently the Spanish application is available on the KCHIP Web site and the others will be available through the Web site soon. Posters, TV and radio advertising have been developed to be sensitive to different racial and ethnic backgrounds.**

- 3.4.5 *Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.*

**The outreach workgroup and the Covering Kids Grant have been invaluable in providing direction and assessing outreach material for reaching varied populations. The number of posters, TV and radio advertisements were increased to reach a broader audience. In a second round of outreach material, families were used to carry the message to other families. It has been affirmed that people who are in trusted relationships with the families are more successful in getting results than any other method and having material, especially the application, in the families' native language is important.**

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

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

<b>Table 3.5</b>				
Type of coordination	Medicaid*	Department for Community Based Services	Other (specify) Dept. for Public Health	Other (specify)
Administration	X (Note 1)			
Outreach		X	X (Note 2)	X (Note 3)
Eligibility determination	X Joint App	X (Note 4)		
Service delivery	X			
Procurement	X			
Contracting	X			
Data collection	X	X	X	
Quality assurance	X Joint Hedis/CAHPS			Univ. of KY, Martin School for Public Policy
Other (specify)				
Other (specify)				

\*Note: This column is not applicable for States with a Medicaid CHIP expansion program only. *(The state designed insurance program did not start until November 1, 1999, which is after the reporting period, but the table has been completed to reflect those activities.)*

**Note 1 – Kentucky Children’s Health Insurance Program (KCHIP) is administratively located in the Department for Medicaid Services, Division Of Children’s Health Programs.**

**Note 2 – The Department for Public Health is contracted to provide comprehensive outreach through the local health departments, manage the statewide hotline, and coordinate receipt of mailed applications.**

**Note 3 – There are a large number of agencies, organizations, advocates and recipients who help coordinate outreach. There is an Outreach workgroup that involves: Department of**

**Education, Department for Mental Health/Mental Retardation, Department of Insurance, Department of Community Based Services, Department of Labor, Office of Family Resource and Youth Services Centers, Head Start Collaboration Office, Commission for Children with Special Health Care needs, Kentucky Chamber of Commerce, Kentucky Hospital Association, KY Chapter of the American Academy of Pediatrics, Cooperative Extension Office, Public Libraries, Area Development Districts, UK Migrant Health Program, KY Robert Wood Johnson Grantee, and individuals representing advocacy groups and recipients. There are other agencies and organizations that have been involved, and the level of involvement is varied.**

**Note 4 – The Department of Community Based Services is contracted to determine eligibility for KCHIP, and this is the same agency that is contracted to determine eligibility for Medicaid.**

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

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

Eligibility determination process:

Waiting period without health insurance (specify) *If health insurance was voluntarily terminated, it is six (6) months*

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

Information verified with employer (specify)

Records match (specify)

Other (specify)

Other (specify)

Benefit package design:

Benefit limits (specify)

Cost-sharing (specify)

Other (specify)

Other (specify)

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

Other (specify)

Other (specify) \_\_\_\_\_

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

**A report is pending from the Department for Community Based Services documenting the number of applicants who indicate that a child or children in the family lost health insurance in the last six months. Planning is underway to include KCHIP Medicaid Expansion applicants as a separate sample in the next Medicaid quality control assessment and to include questions related to crowd out.**

**SECTION 4. PROGRAM ASSESSMENT**

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

*4.1 Who enrolled in your CHIP program?*

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

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

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

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

***IMPORTANT TO NOTE – Kentucky plans to use Table 4.1.1 being compiled by Mathematica; however, after the initial report was sent, revisions were made and data are currently being reviewed for final verification. An amended report of the data will be submitted to HCFA.***

**Table 4.1.1 CHIP Program Type \_\_\_\_\_**

Characteristics	Number of children ever enrolled		Average number of Months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
<b>All Children</b>						
<b>Age</b>						
Under 1						
1-5						
6-12						

13-18						
<b>Countable Income Level*</b>						
At or below 150% FPL						
Above 150% FPL						
<b>Age and Income</b>						
Under 1						
At or below 150% FPL						
Above 150% FPL						
1-5						
At or below 150% FPL						
Above 150% FPL						
6-12						
At or below 150% FPL						
Above 150% FPL						
13-18						
At or below 150% FPL						
Above 150% FPL						
<b>Type of plan</b>						
Fee-for-service						
Managed care						
PCCM						

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

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

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

**KCHIP requires that a family can not voluntarily drop health care coverage within the six months prior to being determined eligible for coverage. An application may be approved in cases where coverage ended less than six months prior to determination of eligibility if the coverage was terminated for reasons beyond the parent's control such as: loss of employment; death of a parent; divorce, where children's coverage had been provided by a non-parental adult; change of employment; change of address so that no employer-sponsored coverage is available; discontinuation of health benefits to all employees of the applicants employer; expiration of the coverage periods established by COBRA; self employment; and termination of health benefits due to a long term disability.**

**There is a question on the application that asks "Did any child lose health insurance in the last six months, and if yes, why?" A report has been requested and is pending from the Department for Community Based Services who is the contracted agent to determine eligibility for KCHIP and who collects this data from the application. The information will be compiled and reported at regular intervals. This information will be available for future reporting periods.**

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

**There are no children's health coverage plans in Kentucky that are funded exclusively with state or municipality dollars. Jefferson County (Louisville) is the only county with a General Assistance mandate, and it does not extend to health coverage for children. Health Kentucky, a program jointly sponsored by state health professional associations, arranges for single visits to volunteer physicians and other health professionals, but eligibility is limited to persons under 100% FPL and thus would only rarely extend to children. Expanded access to commercial health insurance through guaranteed issue, guaranteed renewal, portability, and other market reform initiatives in the early to mid-1990s did not target children, and do not**

**appear to have added children to the rolls of the commercially insured, according to the most recent survey analysis from the Kentucky Legislative Research Commission.**

*4.2 Who disenrolled from your CHIP program and why?*

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

**Data are not available at this time, but it will be available for future reporting periods.**

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

**Data to be collected for future reporting periods. KCHIP Phase II has been operating since July 1, 1999 and re-enrollment will begin in June and July, 2000.**

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

**Note: The data are not available at this time. This is an issue for KCHIP Phase II which was implemented on July 1, 1999.**

**Table 4.2.3**

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

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

4.2.4 *What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?*

- **The month prior to re-certification, the recipient’s caretaker is sent a notice and given an appointment time with a caseworker.**
- **The caretaker can reschedule the appointment time or arrange for another knowledgeable person to keep the appointment. A home visit or telephone interview is possible for “just cause;” however, this is the exception.**
- **If the caretaker does not respond to the notice, a second notice is sent indicating that action must be taken in 10 days or next months benefits may be delayed.**
- **The Kentucky Department for Medicaid Services is currently assessing re-enrollment processes with the objective of simplifying them as much as possible.**

4.3 *How much did you spend on your CHIP program?*

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

FFY 1998                      **\$1,230,695**

FFY 1999                      **\$20,631,661**

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

<b>Table 4.3.1 CHIP Program Type <u>Medicaid Expansion</u></b> (A copy of Kentucky’s spread sheet is included in the appendix.)				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
<b>Total expenditures</b>	\$1,230,695	\$20,631,661	\$975,449	\$16,375,349
<b>Premiums for private health insurance (net of cost-sharing offsets) <u>Capitated Fee for Managed Care</u></b>	375,847	6,030,836	297,896	4,786,675

<b>Fee-for-service expenditures (subtotal)</b>	854,848	14,600,825	677,553	11,588,674
Inpatient hospital services	51,232	1,477,976	40,606	1,165,132
Inpatient mental health facility services	202,487	1,154,085	160,491	916,024
Nursing care services	---	32,240	---	25,588
Physician and surgical services*****	109,747	1,919,100	175,860	1,279,684
Outpatient hospital services	124,788	2,342,969	98,907	1,859,614
Outpatient mental health facility services	23,465	450,108	18,598	357,250
Prescribed drugs	58,320	1,173,554	46,224	931,450
Dental services	47,807	1,108,115	37,892	879,511
Vision services	12,744	260,578	10,101	206,821
Other practitioners' services*	2,141	48,707	1,126	33,137
Clinic services**	17,158	404,121	13,599	320,751
Therapy and rehabilitation services	---	---	---	---
Laboratory and radiological services	4,296	55,078	3,405	43,715
Durable and disposable medical equipment	689	31,333	546	24,869
Family planning	---	61	---	48
Abortions	Not a separate category to capture cumulative costs			
Screening services (EPSDT is listed under physician, primary care & clinic services)	Not a separate category to capture cumulative costs			
Home health	779	54,627	618	43,357
Home and community-based services	179	196,109	141	154,581
Hospice	---	---	---	---
Medical transportation	6,512	419,086	5,161	332,629

Case management***	46,136	2,271,536	36,568	1,802,919
Other services*****	124,268	1,211,441	98,495	961,521

\*Other practitioners services includes – Nurse Anesthetist (54), Nurse Practitioner (75), Audiology (81), and Podiatry (88)

\*\*Clinic Services includes – Special Needs Children (24), Preventive (29), and Rural Health (43)

\*\*\*Case Management includes – Adult Targeted (20), Child Targeted (21), and Title V/DSS (22)

\*\*\*\*Other Services includes – First Steps (30) and EPSDT Related (32)

\*\*\*\*\*Physician and Surgical Services – Physician (74) and Ambulatory Surgical (13)

Source of Data:     Report KyMC 800-R009  
                           Provider Reimbursement Report – KCHIP  
                           Compiled to Annual Report by the Division of Financial Systems

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

What types of activities were funded under the 10 percent cap? \_\_\_\_\_

At this point in time, the 10 percent cap has provided funds for dedicated central office staff to the KCHIP program, general administrative support from the Department for Medicaid Services, contracted support for outreach activities, and contracted eligibility determination services.

What role did the 10 percent cap have in program design? \_\_\_\_\_

Discussions are under way to determine how to use the 10 percent cap to enhance program design. A number of suggestions were listed in the approved state plan; however, a decision has not been made at this time.

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
<b>Total computable share</b>	-0-	595,460				
Outreach		270,000*				
Administration		325,460				
Other _____						
<b>Federal share</b>	-0-	472,617				
Outreach		214,299				
Administration		258,318				
Other _____						

**\*Note:** This amount represents the amount contracted with a public relations firm and the Department for Public Health to work on outreach; however, this does not represent the internal support provided by KCHIP staff, Kentucky Department for Medicaid Services, or time and support by other agencies or advocates.

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

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

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

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

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

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits	MCO		
PCP/enrollee ratios	MCO/PCCM		
Time/distance standards	MCO		
Urgent/routine care access standards	MCO		
Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO		
Complaint/grievance/disenrollment reviews	MCO		
Case file reviews	MCO		
Beneficiary surveys	MCO/PCCM/FFS		

Utilization analysis (emergency room use, preventive care use)	MCO/PCCM		
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

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

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

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

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

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

**There is no information currently available. Some material will be available next year from managed care partnerships. This data will be available within the three year time frame as outlined in the approved plan.**

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

**Managed care organizations will report on access to care when the KCHIP program has been fully implemented. It is anticipated that a report for the January to March, 2000, period will be available from Passport Managed Care Partnership on KCHIP children in July, 2000. The primary care physician to member ratio will be used to monitor access to care. Currently, there is an internal workgroup assessing access to care for PCPs and dentists**

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

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

**Table 4.5.1**

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

\*This is currently accomplished for the Medicaid population in general; however, separate KCHIP reports are to be included in the next state fiscal year.

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

**The Kentucky Department for Medicaid Services commissioned researchers at the Martin School of Public Policy and Administration at the University of Kentucky to implement a satisfaction survey of Medicaid recipients in the Commonwealth. 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 survey results indicate that Medicaid recipients are generally satisfied with their care across the state; the average person rated her or his health care coverage about 4 on a scale of 1 to 5. Over half the recipients reported always seeing the same provider and getting a routine physical in the past six months. Delays and denials for such services as drugs and referrals to specialists are quite low, usually less than five percent.**

**The results are based on mail questionnaires for adult and child Medicaid recipients with about 100 items on each questionnaire. Over 4,000 recipients responded, and enrolled KCHIP Phase I children were included in the sample. Most surveys were received during December 1998 and January 1999. A copy of the most recent client survey is in the appendix.**

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

**The client satisfaction survey for this year includes a separate sample for KCHIP children. The Division of Quality in Kentucky's Department for Medicaid Services is working with leadership to develop a coordinated quality of care for the Department that will include KCHIP. Also, data will be collected and tracked on performance measures related to the outcomes identified in the state approved plan, and quality studies will be identified and conducted.**

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

## **SECTION 5. REFLECTIONS**

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

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

**KCHIP held focus groups for three targeted groups: 1)twenty-one (21) critical leaders who represented policy makers, providers, researchers and advocates; 2)fifteen (15) stakeholders who hold full time professional positions representing KCHIP and Medicaid staff, other involved agencies, contractees and grantees; and 3)eighty (80) targeted low income families from western and central Kentucky. Most of the families (75%) had not enrolled their children in KCHIP.**

**The focus groups responded to questions on the strengths of the KCHIP program, lessons learned and recommendations for improving the KCHIP program. The focus groups provided a basis for the response to this section of the report. A copy of the results are included in the Appendix.**

### *5.1.1 Eligibility Determination/Redetermination and Enrollment*

**Implementation. Using a simplified, mail-in application with a shortened income verification period for KCHIP and Medicaid worked to the benefit of families and eligibility determination workers. It worked so well that the new application and process is now being used with pregnant women.**

**Lessons Learned. Three key issues can be highlighted around the lessons we have learned. While the eligibility determination process was changed, the re-certification process has not been changed, and it has been recognized that to keep children continuously enrolled will require a change in this process as well. A group has been formed to assess**

and recommend changes to the re-certification process. On-going communication and training of outreach and eligibility determination workers is critical to the success of any changes being made. Also, informative and clearly written member information materials will enhance member satisfaction, improve access and reduce staff time needed to field questions and inquiries.

**Evaluation.** On-going evaluation is often centered around continuously monitoring enrollment data, but beyond enrollment data, several issues have emerged that will require more in depth evaluation: 1)to sample KCHIP applicants to determine the quality control effectiveness of the simplified application process; 2)to study current crowd-out prevention strategies beyond the current measure of data collected on the application; and 3)to examine how many children are disenrolling and why.

#### 5.1.2 Outreach

**Implementation.** KCHIP outreach strategies have conveyed an image of the program that has been engaged the public with the result being a positive response. The public image is that KCHIP is *not* welfare and that health care for children is a priority. Promoting outreach as a local effort using multiple entry points and a variety of approaches increases opportunities to reach more targeted low-income families.

To illustrate the types of methods and approaches used to strengthen the outreach efforts, the following is a list of ten activities that have been conducted during the current SFY:

- held a huge media event featuring Naomi Judd to kick-off KCHIP Phase II;
- contracted with a public relations firm to develop materials and coordinate media events;
- designed and printed the simplified application and posters;
- developed and implemented a media campaign involving TV, radio and newspaper advertising;
- contracted with public health to coordinate local outreach efforts;
- hosted a KCHIP booth at the State Fair;
- developed a Speakers Bureau including training of trainers and distributing materials to support local engagements;
- worked with the Department of Education to coordinate KCHIP outreach with the school lunch program and other KDE programs;
- established a targeted outreach campaign to Hispanic speaking residents; and
- targeted 1,000 employers to support outreach efforts.

**Lessons Learned.** One of the early lessons was that advertising dollars significantly promote public awareness. Another was the importance of culturally sensitive approaches and materials. Finally, outreach must be viewed as a continual process that requires a long-range strategic plan sensitive to the targeted low-income families and the local outreach workers.

**Evaluation.** Later this fiscal year four to five focus groups will be held with targeted low-income families who have not enrolled in KCHIP to identify strategies to increase awareness and action to increase applications. Also, a two day strategic planning retreat will be held involving 60 participants including members, advocates, outreach workers and staff. A copy of the results of the survey to evaluate outreach is included in the appendix.

5.1.3 *Benefit Structure*

**Comments.** The benefit structure is tied to Title XIX. KCHIP Phase I and II are Medicaid expansions, and Phase III is a Medicaid look-alike which includes the same benefit package and structure as Medicaid with the exception of EPSDT special services and non-emergency transportation. The richness of the benefit package has been recognized as an asset to the program. In fact, some think KCHIP benefits are too generous.

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

NA

5.1.5 Delivery System

**Comments.** State legislation required that KCHIP be fully implemented statewide within one year of the Title XXI State Plan approval which translated to KCHIP being fully implemented by November, 1999. The Title XXI State Plan was approved to develop a state designed health insurance program that would utilize managed care organizations to deliver services; however, it was determined that a new children's health insurance program utilizing MCO's statewide could not be implemented within the time constraints. An alternative was adopted to use the established infrastructure; thus, KCHIP Phase II was implemented on July 1, 1999, which is a Medicaid expansion for children from 1 through 18 in families up to and including 150%

**FPL. KCHIP Phase III was implemented on November 1, 1999, which is a state designed program and more specifically a Medicaid look-alike for children from birth through 18 in families up to and including 200% FPL.**

**Implementation.** Using the established infrastructure streamlines and eases implementation for providers. Using a practical and flexible approach to the delivery system results in promoting creative methods of getting health services to children. Utilizing an advisory council and committed staff can have a positive impact on providing health coverage to children that did not have it before.

**Lessons Learned.** The approach to getting the delivery system in place has built positive partnerships in and out of state government. Communication between and among different interest groups becomes a key factor in maintaining program flexibility and continuing to work toward the goals and objectives.

It must be acknowledged that program planning is dependent on environmental context, and it is not possible to go where the market is not ready to go. Integrating private health plans and public health plans may not be feasible, without significant time invested in initial planning. In conclusion, it should be remembered that programs can and do change, but the lessons from the past can help guide future directions.

**Evaluation:** Access is an emerging issue that has resulted from the incredibly rapid and expanding enrollment. Work groups within Medicaid and KCHIP have been established to assess provider adequacy on an on-going basis and to develop a plan to continually recruit additional providers as needed.

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

**Comments.** Kentucky's policy on crowd-out requires that a child must be without health insurance for six months if the caretaker voluntarily discontinues health insurance. This continues to be an issue that targeted low-income families and advocates question, and is an issue that will require further evaluation.

General comments about concerns on KCHIP's effect on private health plans can be summarized as "it never became an issue." The private health insurance market has been unstable in Kentucky, and at this stage in KCHIP's development, it has not affected this market.

#### *5.1.7 Evaluation and Monitoring (including data reporting)*

**Comments.** Timely tracking and data are essential; however, the automated systems that are readily available were primarily designed to track service delivery for payment to providers. Thus, tracking data to measure performance and outcomes is more difficult. Contracts with managed care organizations require tracking encounter data that will provide better information on prevention and quality care. The difficulty is one of time and expense

5.1.8 *Other (specify)*

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

## **Recommendations for Improving the KCHIP Program**

### **Eligibility**

- Study current crowd-out prevention strategies
- Study the need for more eligibility workers to address the volume of increased applications
- Continue to evaluate issues related to presumptive eligibility
- Explore the feasibility of expanding income eligibility levels and expanding eligibility to parents, as federal and state policy changes

### **Enrollment and Re-enrollment**

- Simplify re-enrollment process
- Develop an easy to understand member packet on services, benefits, rights and responsibilities
- Investigate the electronic transfer of applications from outreach sites or consumers to eligibility determination sites

### **Access (Recruitment and Retention of Providers)**

- Assess provider adequacy on an on-going basis
- Develop a continuing plan to recruit additional providers as needed

### **Quality**

- Develop methods to promote healthier lifestyles for children and families

- **Assess the health status of KCHIP children**

**Infrastructure (Administration and Management)**

- **Continue to provide an adequate budget for effective outreach strategies**
- **Assure funding is available to support the KCHIP Program and any program improvements which are adopted**
- **Improve internal and external communication between stakeholders**
- **Explore the use of EBT cards as overall EBT technology expands in Kentucky**

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

- **Retain program flexibility that allows States' to institute a state designed children's health insurance program.**
- **Federal leadership on eligibility simplification and outreach has provided support for effective change and efficient implementation. This same leadership could be beneficial in measuring outcomes and quality of care.**
- **Until the program is fully implemented, it is difficult to estimate administrative costs and develop a plan for expenditures within the allowable time frames. More flexibility in this area would support implementation efforts.**
- **The program is growing at a faster rate than anticipated. Critical leaders and families have expressed a desire to see the program expanded to include higher income guidelines and family coverage. However, it is not likely that this could be achieved without expanded support at the federal level.**

**Summary:**

**KCHIP...is making a difference. Beverly Taul is thrilled to have found out about KCHIP!**

**A 36-year-old mom, Beverly works as a school secretary in Marion County to provide for her children, ages seven, 10,13 and 16. She is proof positive that going beyond the norm with outreach efforts does make a difference. Beverly couldn't afford health coverage for her children, causing her constant anxiety. "I worried that if something happened, what would I do," she said. "There were times I didn't take them to the doctor when I really should have." Lacking coverage for 16-year-old Eric was particularly frightening. Eric has acute medical needs since he was born with cleft lip and palate and regularly travels to a clinic in Louisville operated by Kosair Charities.**

**During one of the clinic visits, Beverly saw a KCHIP poster on a bulletin board. But, it was not until attending the Ham Days Festival in Lebanon last September, 1999, that the connection was solidified. At a KCHIP booth set up by Passport**

**Health Plan, Beverly met outreach worker Marcelline Coots. Through her efforts, and with help from the Department for Community Based Services office in Lebanon, Beverly was able to get health coverage for her kids including KCHIP for Eric.**

**“I was so excited to get Eric on KCHIP, “ Beverly said. “In addition to covering his clinic visits, I’ve taken care of dental work and glasses that he badly needed. I can’t tell you what a difference it’s made.”** *(This story was taken from a quarterly Newsletter entitled KCHIP News & Best Practices on Covering Kentucky Kids.)*

## **APPENDIX**

### **A**

#### **KCHIP Chart on Children Targeted by Phases**

### **B**

#### **Report on Targeted Low Income Families Questionnaire & Focus Groups**

**C**

**A Survey of Outreach Approach and Settings in Kentucky**

**D**

**The 1998-1999 Kentucky Medicaid Recipient Satisfaction Survey**

**E**

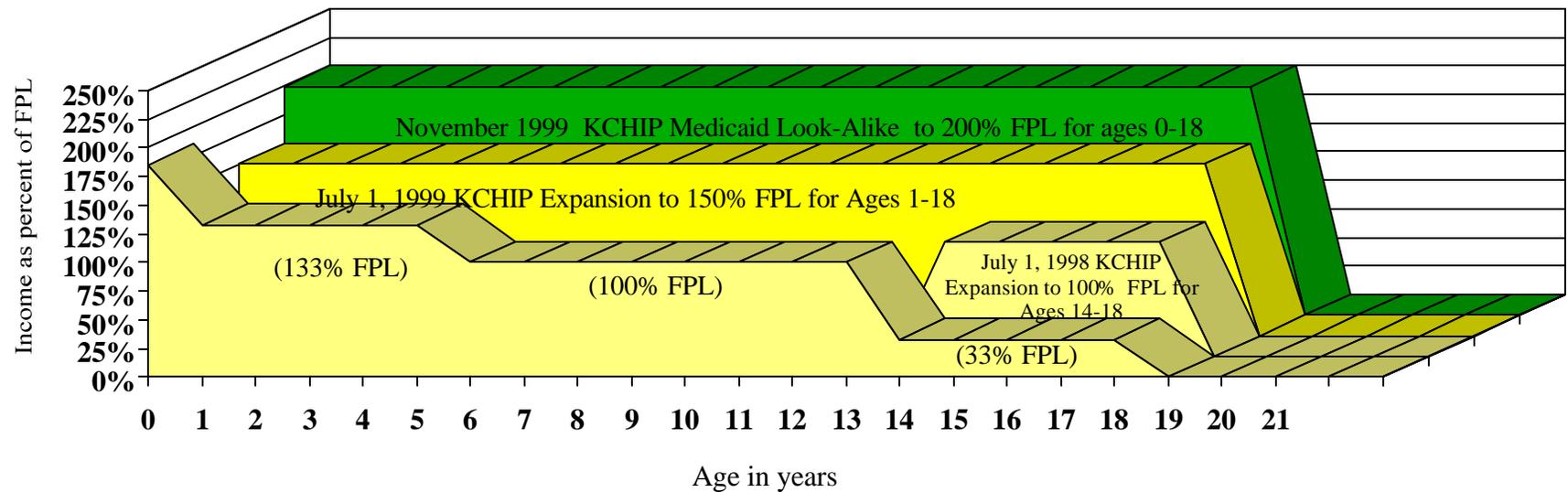
**Report on Combined Results from Focus Groups SFY2000  
Involving Critical Leaders – Stakeholders – Targeted Low Income Families**

**Attached**

**KCHIP Speaker Resource Kit & Building Health Families Video**

03/30/00

# Income and Age Eligibility for Health Services Provided by Medicaid Through the Kentucky Children’s Health Insurance Program (KCHIP)



**Traditional Medicaid**

Age Group	% of Medicaid
<1	185
1-5	133
6-13	100
14-18	100

## Targeted Low Income Families Questionnaire & Focus Groups

### Introduction

KCHIP engaged the local health departments to coordinate outreach efforts through four regional liaisons. The liaisons were responsible for conducting focus groups in December, 1999, and January, 2000. The purpose was to discover what targeted low-income families believe are effective approaches to outreach and to develop strategies for future outreach efforts.

The results were reported from five groups representing a total number of 80 respondents. One of the groups represented the Hispanic population of central Kentucky. The results represent groups in Fayette County, Christian County, and Green River Health District. Other focus groups were held in Clay County and Jefferson County.

Three approaches were used to collect information: 1) organized discussion groups; 2) telephone interviews; and 3) one-on-one questionnaires. There were four questions: why is it important to have health insurance for your children; 2) what are the best ways to help families enroll their children in KCHIP; 3) why do you think families do not enroll their children in KCHIP, if they do not have health insurance; and 4) what would prevent you or other families from re-enrolling your child in KCHIP in a second year?

Twenty of the respondents indicated that their children were enrolled in KCHIP, and two of the respondents indicated that their applications for KCHIP were pending. Of the remaining 58 respondents 12% had private insurance 38% were enrolled in Medicaid and the others were uninsured. Only 7 respondents indicated that they were somewhat dissatisfied with their children's health care; however, five of those, who were somewhat dissatisfied, spoke Spanish. Follow-up needs to be done to determine the reason for their dissatisfaction.

### Results

#### 1) Why is it important to have health insurance for you children?

REASON	PERCENT	EXAMPLES OF RESPONSES
Financial	36%	Provide payment for health treatment. They get sick-you have coverage. Sometimes we don't want to go to the Dr. because we don't have insurance – can not afford to go to Dr. without some help.
Health & Well-being	32%	For shots and to stay healthy. To make sure they are healthy. It feels good. Children should be first priority.
Access	27%	In order to have someplace to take my child when need arises. If he

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		gets sick he has a Dr. In case of an emergency.
Other	4%	School requirement.

### What are the best ways to help families enroll their children in KCHIP?

SUGGESTED APPROACHES	PERCENT	EXAMPLES
Targeted contact points in community	30%	Health department, schools, churches, stores, booths & fairs, place of employment, doctors' offices, hospitals, agencies such as community action & DCBS
Word-of-Mouth or One-on-one	26%	Talk to the family about it. Locating people door to door.
Advertising	18%	Most often mentioned was TV, but radio, newspapers, yellow pages were also mentioned.
Posters	11%	Respondents mentioned seeing posters in waiting areas or waiting in line for services and at stores.
Education	5%	Presentations at meetings and receiving material through the mail.
Other	9%	A myriad of responses: up income level, not reading material, help with paper work, sell benefits, give out applications and keep it simple.

### 3. Why do you think families do not enroll their children in KCHIP, if they do not have health insurance?

REASONS	PERCENT	EXPAMPLES OF RESPONSES
Not Aware of Program	38%	They don't know about program. May not know if children are not in school.
Afraid families will have to pay	36%	They think it costs a lot of money. People may be worried expenses may fall back on them. When people hear "insurance" they think they would have to pay or a co-pay is involved.
Don't understand or need more information	14%	Don't think they would qualify. Afraid they will have to give lots of personal information.
Too passive or inert	6%	It might be too hard a process so don't even try. Don't want to bother with it. They're just lazy.
Stigma	5%	Think it is a "handout"; too much pride.
Communication	4%	One focus group's first language was Spanish, and language was a barrier.

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Other	4%	Paperwork, immigration issues, trust..
No Opinion	2%	

4. **What would prevent you or other families from re-enrolling your child in KCHIP in a second year?**

<b>PRIORITY</b>	<b>REASON</b>	<b>EXAMPLE</b>
1	Nothing	If they are satisfied with the program, most families will re-enroll their children in KCHIP.
2	Become ineligible	Increased income, move out of state, employer purchased insurance.
3	Lack of access or quality	Limited doctor choice, not satisfied with providers, didn't show me the quality that I needed.
4	Increased requirements	More paper work added to process of re-enrolling, going to an office, more hassle.
5	Others	Uncertain about future, lose information or don't know how.

**Additional Comments:**

- **Positive experiences with KCHIP and enrolling**
- **Liked not having to go to welfare office**
- **Not having to sit through classes or see a caseworker**
- **Appreciative of KCHIP for children**
- **Easier process to get enrolled than expected**
- **Pretty high income guidelines**
- **Application was easy to complete**
- **KCHIP hotline was helpful**

**Summary**

It is apparent from the responses that a variety of approaches are necessary for effective outreach; however, some are more effective than others. It is important to get as many people in the community that have regular contact or contact to provide health services involved in outreach as possible. It is also important to get people who are in trusted positions involved with spreading the word, especially if they can provide direct assistance in completing the paperwork. Another lesson to be learned from the respondents is that many people still have not heard about KCHIP – outreach is an ongoing process!

There are additional considerations for policy makers. It is important to be culturally sensitive in the approaches used with minority populations. Education and information related to immigration status needs to be addressed. Many respondents indicated that they did not need help to completing the application, but a

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number of respondents provided reminders to keep it simple and provide multiple access points where targeted low-income families can receive assistance. with the application.

In conclusion, targeted low-income families want comprehensive, quality health insurance for their children that they can afford. While financial issues were of primary consideration, families were also concerned about the overall health and well being of their children. They believed that well-child check-ups and immunizations were important.

**KCHIP Outreach Strategies**

**Executive Summary**

The following are the highlights of the survey of the KCHIP outreach workers:

**Effective Approaches**

The respondents identified the following as the top three effective approaches

- \* Brochures/flyers (85%)
- \* Promotional Items (68%)
- \* Signs/posters (66%)

**Effective Settings**

The respondents identified the following as the top three effective settings

- \* Schools (90%)
- \* Local/Community Health Centers (87%)
- \* Community Sponsored Events (77%)

**Three Most Effective Settings in Conducting the Outreach Program**

The respondents identified three most effective settings as:

- \* Schools (20%)
- \* Community Events (12%)
- \* Home Visits (10%).

**Biggest Hurdle in Convincing the Enrollees**

The respondents listed the following top three biggest hurdles in convincing the potential enrollees to complete and mail an application:

- \* The stigma of welfare (13%)
- \* Getting (preparing) the information needed together (9%)
- \* Fear of not qualifying or denial (9%) and Helping them fill out and mail applications (9%).

### **Suggestions to Improving the KCHIP Application**

The respondents suggested the following top three changes to the application:

- \* Discontinue the 6-month waiting period (5%)
- \* Shorten it (condense information) (4%)
- \* Use larger Type (4%)

### **Feedback from the Enrollees**

Of the total respondents who answered this question, a majority of them (57%) said that the clients appreciated the benefits of the KCHIP program. They used words such as "pleased," "thankful," "relieved," "positive," to describe client's appreciation of the program. One respondent thus reflected about the positive impact of the KCHIP program, "*One teenage girl told me that if it had not been for KCHIP she would probably have cancer by now....*"

Of the other responses, the top three feedback responses included the following

- \* Not enough doctors in the program (9%)
- \* Long wait for approval (9%)
- \* Difficult to find a dentist in the KCHIP program (4%)

### **Feedback from those who did not Enroll**

The respondents identified the top three feedback categories from families who did not enroll in KCHIP program as:

- \* High income levels (20% )
- \* Prior insurance (13 %)

- \* Welfare stigma (7%)

### **Three Most Effective Strategies or "Best Practices" for Enrolling Children of All Ages**

Of the total survey responses, the three most effective strategies or "best practices" for enrolling children of all ages were:

- \* Schools, including school nurses and PTO (14%)
- \* Advertising, including TV spots, PSAs and newspaper ads (9%)
- \* Door to door (7%); and Health department (7%)

### **Most Effective Agencies in Helping to Get Children Enroll**

Of the total survey responses for the most effective agencies to get enrolled in the KCHIP program, the top three included the following:

- \* Health Departments (24%)
- \* Family Resource Centers (19%)
- \* Schools (17%)

## **KCHIP Outreach Strategies**

### **A Report of Effective Outreach Tools**

#### ***I. Effective Approaches for Enrollment***

### **1. Network Television Advertising**

Half the respondents (50%) said that network television advertising is effective or most effective. Only 8% felt that this approach is somewhat effective or least effective. About 38% rated this approach as average. Four percent of the respondents did not use the program.

### **2. Cable Television Advertising**

Less than half the respondents (44%) felt that cable television advertising is effective or most effective. One-tenth of the respondents (10%) thought that this approach is somewhat effective. About 38% rated this approach as average. Eight percent of the respondents did not use the program.

### **3. Radio Advertising**

**A little more than half the respondents (52%) felt that radio advertising is effective or most effective. While 12% rated that this approach as somewhat effective or least effective, 28% rated this approach as average. 8% of the respondents did not use the program.**

### **4. Newspaper Advertising**

**More than half the respondents (58%) felt that newspaper advertising is effective or most effective. About 12% felt that this approach is somewhat effective or least effective. About 26% rated this approach as average. Four percent of the respondents did not use the program.**

### **5. Brochures/Flyers**

**A high majority of the respondents (85%) felt that brochures/flyers are effective or most effective. In contrast, only 2% felt that this approach is somewhat effective or least effective. About 13% rated this approach as average.**

### **6. Direct mail**

**A little more than half the respondents (54%) thought that direct mail is effective or most effective. In contrast, only 8% thought that this approach is somewhat effective or least effective. About 19% rated the approach as average. About 19% of the respondents did not use the program.**

### **7. Education sessions**

**About 62% of the respondents thought that education sessions are effective or most effective. In contrast, only 4% thought that this approach is somewhat effective. About 21% rated this approach as average. About 14% of the respondents did not**

use the program.

**8. Home visits by State/enrollment broker/administrative contractor**

About 40% of the respondents thought that home visits by state/enrollment broker/administrative contractor are effective or most effective. In contrast, only 6% felt that this approach is somewhat effective. About 11% rated this approach as average. About 43% of the respondents did not use the program.

**9. The state hotline (1-877-KCHIP18)**

A little over half the respondents (53%) felt that the state hotline is effective or most effective. In contrast, only 15% felt that this approach is somewhat effective or least effective. About 23% rated the state hotline as average. About 9% of the respondents did not use the program.

**10. Billboards**

Slightly less than one-fifth of the respondents (18%) thought that billboards are effective or most effective. Almost the same proportion of respondents (16%) thought that this approach is somewhat effective or least effective. Another 16% of them rated the program as average. About half of the respondents (50%) did not use the program.

**11. Promotional Items**

Two-thirds of the respondents (68%) thought that promotional items are effective or most effective. In contrast, only 8% thought that this approach is somewhat effective or least effective. About a fifth of the respondents (21%) rated the approach as average. About 4% of the respondents did not use the program.

**12. Non-traditional hours for application intake**

Respondents accounting for 62% of the survey felt that non-traditional hours for application intake are effective or most effective. In contrast, 9% of the respondents felt that this approach is somewhat effective or least effective. About 17% rated this approach as average. About 11% of the respondents did not use the program.

**13. Public transportation ads**

While 12% of the respondents felt that the public transportation ads are effective or most effective, about 15% felt that this approach is somewhat effective or least effective. About 12% rated this approach as average. Close to two-thirds of the respondents (65%) did not use the program.

**14. Signs/posters**

**Slightly less than two-thirds of the respondents (66%) felt that signs/posters are effective or most effective. In contrast, only 8% felt that signs/posters are somewhat effective or least effective. A fourth of them (25%) rated this approach as average. About 2% of the respondents did not use the program.**

**15. State/broker initiated phone calls**

**A little more than a fourth of the respondents (27%) thought that state/broker initiated phone calls are effective or most effective; 14% of them thought that this approach is somewhat effective or least effective. About 16% of the respondents rated this approach as average. About 43% of the respondents did not use the program.**

**16. Other Approaches (See under "Data analysis of KCHIP approaches and settings for the evaluation process)**

**17. Other Approaches (See under "Data analysis of KCHIP approaches and settings for the evaluation process)**

*II. Effective Sites for Enrollment*

**18. Battered women shelters**

**Six percent of the respondents thought that battered women shelters are effective or most effective. About 10% felt that this setting is least effective. About 8% rated this approach as average. More than three-fourths (77%) of the respondents did not use the setting.**

**19. Community sponsored events**

**A little more than three-fourths (77%) of the respondents thought that community sponsored events are effective or most effective. In contrast, only 13% thought that this setting is somewhat effective or least effective. About 8% rated this**

approach as average. About 2% of the respondents did not use the setting.

#### **20. Beneficiary's home**

About 42% of the respondents thought that beneficiary's home is effective or most effective. In contrast, only 17% thought that this setting is somewhat effective or least effective. About 11% of them rated this setting as average. Less than one-third of the respondents (30%) did not use the setting.

#### **21. Day care centers**

A little less than two-thirds of the respondents (66%) thought that day care centers are effective or most effective. In contrast, only 6% thought that this setting is somewhat effective or least effective. About 17% rated this setting as average. About 11% of the respondents did not use the setting.

#### **22. Faith communities**

About 45% of the respondents thought that Faith communities are effective or most effective. About 9% thought that this setting is somewhat effective or least effective. About 32% rated this setting as average. About 13% of the respondents did not use the setting.

#### **23. Fast food restaurants**

About half the respondents (51%) felt that fast food restaurants are effective or most effective. In contrast, 8% felt that this setting is somewhat effective or least effective. While a fifth of the respondents (21%) rated this setting as average, about the same proportion of them (21%) did not use the setting.

#### **24. Grocery stores**

About 59% of the respondents felt that grocery stores are effective or most effective. In contrast, only 7% felt that this setting is somewhat effective or least effective. About 17% rated this setting as average. About 15% of the respondents did not use the setting.

#### **25. Homeless shelters**

Less than one-tenths of the respondents (9%) felt that homeless shelters are effective or most effective. Two percent of them felt that this setting is somewhat effective or least effective. About 17% rated this setting as average. About 72% of the respondents did not use the setting.

### **26. Job training centers**

About 18% of the respondents felt that job training centers are effective or most effective. In contrast, only 2% felt that this setting is somewhat effective or least effective. About 19% rated this approach as average. Slightly over half the respondents (51%) did not use the setting.

### **27. Laundromats**

About 21% of the respondents felt that laundromats are effective or most effective. A tenth of the respondents (10%) felt that this setting is somewhat effective or least effective. About 21% rated this approach as average. About half of the respondents (49%) did not use the setting.

### **28. Libraries**

Around one-third of the respondents (32%) thought that libraries are effective or most effective. Only 15% thought that this setting is somewhat effective or least effective. Another third of them (34%) rated this setting as average. About 19% of the respondents did not use the setting.

### **29. Local/community health centers**

A very high majority (87%) of the respondents thought that local/community health centers are effective or most effective. None of the respondents thought that this setting is least effective. About 8% rated this setting as average. About 6% of the respondents did not use the setting.

### **30. Point of service/provider locations**

More than half the respondents (62%) felt that the point of service/provider locations are effective or most effective. In contrast, only 8% felt that this setting is least effective. While 23% of the respondents rated this setting as average, about 8% of them did not use the setting.

### **31. Public meetings/health fairs**

Close to three-fourths of the respondents (72%) felt that public meetings/health fairs are effective or most effective. In contrast, only 8% felt that this setting is somewhat effective or least effective, and 17% rated this setting as average. About 4% of the respondents did not use the setting.

### **32. Public housing**

About 57% of the respondents felt that public housing is effective or most effective. In contrast, only 8% felt that this setting

is somewhat effective or least effective. About 17% rated this setting as average and 19% of the respondents did not use the setting.

### **33. Refugee resettlement programs**

A small number of respondents (6%) felt that refugee resettlement programs are most effective. Eight percent of them felt that this setting is least effective. None of them rated this setting as average. A very high majority of respondents (87%) did not use the setting.

### **34. Adult education sites**

About 31% of the respondents thought that school/adult education sites are effective or most effective. In contrast, only 9% thought that this setting is least effective. About 37% rated this setting as average. About a fifth of them (22%) did not use the setting.

### **35. Senior centers**

Fifteen percent of the respondents thought that senior centers are effective or most effective. Less than a fourth of them (23%) thought that this setting is somewhat effective or least effective. About a fifth of them (19%) rated this setting as average. About 42% of the respondents did not use the setting.

### **36. Social service agency**

More than half the respondents (53%) thought that social service agency is effective or most effective. In contrast, only 8% thought that this setting is least effective. About 18% rated this setting as average. About a fifth of them (22%) did not use the setting.

### **37. Workplace**

Sixty five percent of the respondents felt that workplace is effective or most effective. In contrast, only 10% felt that this setting is least effective. About 15% rated this setting as average. About 10% of the respondents did not use the setting.

### **38. Schools**

An overwhelming majority of the respondents (90%) felt that schools are effective or most effective. In contrast, only 4% felt that this setting is least effective. About 4% rated this setting as average. About 2% of the respondents did not use the setting.

39. Parent training meetings

**More than half the respondents (55%) felt that parent training meetings are effective or most effective. In contrast, only 10% felt that this setting is least effective. About 12% rated this setting as average. About a fourth of the respondents (24%) did not use the setting.**

**40. Other Approaches (See under " Research Report of KCHIP Approaches and Settings for the Evaluation Process")**

**41. Other Approaches (See under " Research Report of KCHIP Approaches and Settings for the Evaluation Process")**

**Q) 42. What do you think are the three most effective settings for conducting the outreach program\***

The respondents identified three most effective settings as: (1) Schools (20%); (2) Community Events (12%); and (3) Home Visits (10%). The following are the other most effective settings identified by the respondents:

- Health centers 9.0%
- Health departments 7.5%
- Grocery and retail Stores 5.0%
- One-on-one 4.7%
- Television 4.7%
- Family Resource Centers and  
Day care centers 4.0%
- Direct mail 4.0%
- Social Service Agencies 3.4%
- Businesses 2.7%
- Health fairs 2.7%
- Workplace 1.3%
- Non-traditional hours 2.7%
- Fast food restaurants 1.3%

- Youth Service Centers 0.7%
- Newspapers 0.7%
- Phone calls 0.7%
- Radio 0.7%
- Flyers 0.7%
- Factories 0.7%
- Churches 0.7%

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\*N=147 responses

**Q) 43. In your experience, what is the biggest hurdle in convincing the potential enrollees to complete and mail an application?\***

The respondents listed the following top three biggest hurdles in convincing the potential enrollees to complete and mail an application: (1) The stigma of welfare (13%); (2) Getting (preparing) the information needed together (9%); and (3) Fear of not qualifying or denial (9%) and Helping them fill out and mail applications (9%). The other respondents identified the following biggest hurdles in convincing the potential enrollees to complete and mail an application:

- Just taking time to do 6.0%
- Check stubs to be mailed with the application 3.7%
- Completing the application 3.7%
- Time consuming 3.7%
- Illiteracy 3.7%
- Previous denial 3.7%
- Skeptical or didn't understand that it is free 3.7%
- Don't want to reveal financial background 3.7%
- Making photocopies 3.7%
- Families not making effort to follow through 1.8%
- Fear that KCHIP may affect other benefits 1.8%
- Six month waiting period 1.8%

• Apathy, “never get something for nothing attitude”	1.8%
• Lack of info	1.8%
• Convincing them that they are eligible (understanding the application)	1.8%
• Embarrassment	1.8%
• Turn around time	1.8%
• Income	1.8%
• Did not get supplies in time	1.8%
• New guidelines	1.8%
• Previous unpleasant experience with DCBS	1.8%
• Dentists not accepting KCHIP	1.8%
• Convincing them to check their income for qualification	1.8%

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\*N=54 respondents

#### **Q) 44. How could the application be improved?**

Of the total number of respondents, about two-thirds (64%) of them stated that they like the application in its current form. Of the remaining respondents the following suggestions, to improve the application, emerged as top three: (1) Discontinue the 6-month waiting period (5%); (2) Shorten it (condense information) (4%); and (3) Use larger Type (4%). The rest of the respondents suggested the following changes to improve the application:

- State if you have Medicaid or Kentucky Health Select 2.0%

- Explain they don't qualify if they don't have insurance 2.0%
- The KCHIP card should resemble insurance card 2.0%
- Insert a line for family doctor 2.0%
- Embolden required items 2.0%
- Make it more simple 2.0%
- On the mailing envelope, identify as KCHIP application 2.0%
- List exactly on the application or envelope what is needed in addition to the application 2.0%
- Postage paid envelope could be addressed to go to the DCBS in the county 2.0%
- Request yearly income instead of monthly income 2.0%
- Explain on the application what to do if you need assistance in filling out application 2.0%

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\*N=19 respondents ; Note: some respondents provided more than one answer.

**Q) 45. Approximately how many applications have been filled out in your district? (See under "KCHIP Outreach Survey Demographic Information)**

**Q) 46. Please answer the following demographic information about yourself:**

- a. Managed care partnership region**
- b. Employer/organization**
- c. County/health district**
- d. Title/position**

**(See under "KCHIP Outreach Survey Demographic Information)**

**Q) 47. Please provide any feedback that you have received from the enrollees about the KCHIP program.\***

Of the total respondents who answered this question, a majority of them (57%) said that the clients appreciated the benefits of the KCHIP program. They used words such as "pleased," "thankful," "relieved," "positive," etc. to describe client's appreciation of the program. One respondent thus reflected about the positive impact of the KCHIP program, *"One teenage girl told me that if it had not been for KCHIP she would probably have cancer by now...."* Of the other responses, the top three feedback responses included: (1) Not enough doctors in the program (9%); (2) Long wait for approval (9%); and (3) Difficult to find a dentist in the KCHIP program (4%). The rest of the feedback responses included the following:

- Not hearing about approval in 30 days 2.0%
- Great help for glasses and dental care 2.0%
- Slow qualification process 2.0%
- Make it available for parents 2.0%

- Applications were processed quickly 2.0%
- Can't reach anyone at the state hotline 2.0%
- Worried about how long the program will last 2.0%
- Easy to fill out (application) 2.0%
- Six-month wait is frustrating 2.0%
- Angry that program was pushed but has no providers 2.0%

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\*N=54 respondents

**Q) 48. If you had a chance to interact with families who did not enroll in KCHIP program, what feedback have you received from them?\***

The respondents identified the top three feedback categories from families who did not enroll in KCHIP program as: (1) High income levels (20% ); (2) Prior insurance (13 %); and (3) Welfare stigma (7%). Other respondents had the following to say about feedback from those who did not enroll in KCHIP program:

- They "just didn't do it" 3.3%
- Ineligible 3.3%
- Upset with six month waiting period 3.3%
- Did not hear of the program 3.3%
- No time to make copies of (required) information 3.3%
- Could not fill out application 3.3%
- Unfair income guidelines 3.3%
- Covered by other insurance 3.3%
- Seems like they are hiding from someone 3.3%
- Received response from KCHIP in a timely manner 3.3%

- Not aware that their income qualified 3.3%
- Did not want to declare paternity 3.3%
- Angry because of unfair insurance requirements 3.3%
- Wished it (KCHIP program) were available when the children were younger 3.3%
- Mailed (the application) but never heard 3.3%
- Age limits for children 3.3%
- Some didn't get income statements together 3.3%
- Long wait for approval 3.3%

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\*N=30 respondents

**Q) 49. What do you think are the three most effective strategies or "best practices" for enrolling children of all ages?\***

Of the total survey responses, the three most effective strategies or "best practices" for enrolling children of all ages were: (1) Schools, including school nurses and PTO (14%); (2) Advertising, including TV spots, PSAs and newspaper ads (9%); (3) Door to door (7%); and Health department (7%). Other responses suggested the following strategies or "best practices" for enrolling children of all ages:

- One-on-one 6.0%
- Direct mailing 6.0%
- Community events 5.0%
- Help filling out application 5.0%
- Phone calls 5.0%
- Health centers 5.0%
- Making KCHIP application accessible 4.0%
- Mail-in enrollment 4.0%
- Educating parents about KCHIP 3.0%
- Reaching parents 3.0%
- Follow up 2.0%
- Target new parents 2.0%
- Health fairs 2.0%
- Family resource centers 2.0%
- One application for all children 1.0%
- Recruiter/KCHIP workers 1.0%
- Friendly help at DCBS 1.0%
- Waive six-month waiting time 1.0%
- Keep income levels reasonable 1.0%
- Education 1.0%
- Businesses 1.0%
- Provide step-by-step instruction 1.0%
- Free/reduced lunch sign-ups 1.0%
- Lack of photocopying facilities 1.0%
- Partnership with low-paying employers 1.0%
- Evening/weekend contact with businesses 1.0%

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\*N=102 responses

**Q) 50. Who or what agencies have been most effective in helping to get children enrolled?\***

Of the total survey responses for the most effective agencies to get enrolled in the KCHIP program, the top three included the following: (1) Health Departments (24%); (2) Family Resource Centers (19%); and (3) Schools (17%). The other responses suggested the following as the most effective agencies to get children enrolled in the KCHIP program:

- Health centers 9.0%
- Youth service centers 4.7%
- KCHIP workers 4.0%
- State agencies 4.0%
- Head Start 2.8%
- Churches 2.8%
- BSI/CBS 2.8%
- TV 1.8%
- Businesses (including fast food restaurants) 1.8%
- Migrant farm worker health programs 0.9%
- Temporary employment agencies 0.9%
- Housing authorities 0.9%
- Community centers 0.9%
- Ryland food program 0.9%
- Direct service organization 0.9%
- Factory 0.9%

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\*N=106 responses

## **Combined Results from Focus Groups SFY2000 Critical Leaders – Stakeholders – Targeted Low Income Families**

### **Introduction**

KCHIP held focus groups for three targeted groups: 1) twenty-one (21) critical leaders who represented policymakers, providers, researchers and advocates; 2) fifteen (15) stakeholders who hold full time professional positions representing KCHIP and Medicaid staff, other involved agencies, contractees and grantees; and 3) eighty (80) targeted low income families from western and central Kentucky. Most of those families (75%) had had not enrolled their children in KCHIP.

The combined results are in response to three questions posed to the critical leaders and stakeholders. The three questions are: 1) what have been the strengths of the KCHIP program; 2) what lessons have we learned; and 3) what recommendations do you have for improving the KCHIP program over the next two years. An asterisk (\*) has been used to denote where there is consensus across the different focus groups. The targeted low income families were not ask these three questions directly, but inferences have been made as appropriate.

### **Results**

#### **1. What have been the strengths of the KCHIP Program?**

##### ***Underlying Issues***

- \*Richness of benefit package,
- \*Builds positive partnerships in and out of state government, including the federal government,
- \*No cost to families with high income guidelines,
- \*Public image is that KCHIP is *not* welfare and excellent support for welfare reform,
- \*Acceptance and recognition that health care for children is a priority,
- Provides health coverage to children that did not have it before,
- Engages the public with the result being a positive response,
- Federal regulations allow for state flexibility,
- Utilizes an advisory council,
- Avoids preconceptions, and
- Provides relief for employers in terms of more benefits for families.

***Outreach & Application Process***

- \*Simplifies, two-page application for Medicaid and KCHIP'
- \*Simplifies mail-in application process for Medicaid and KCHIP'
- \*Accessibility of KCHIP through multiple entry points,
- \*Uses a variety of outreach approaches; i.e., radio & TV spots, school programs, Promotes outreach in each county,
- Translating the application into Spanish, and
- Advertising dollars significantly promotes public awareness.

***Implementation Accomplishments***

- \*Uses established infrastructure,
- \*Streamlines and eases implementation for providers,
- \*Dedicated and committed staff who advocate for program has a positive impact, Incredibly rapid enrollment,
- Promotes creative ways of getting health services to children, and
- Uses flexible and practical approach.

***Short-term Achievements***

- \*Provides additional protections to families by having healthier children,
- Allows accessing additional grant money such as Robert Wood Johnson Covering Kids Grant,
- Working model of “doing the right thing,”
- Eases the fiscal burden on providers,
- Brought public health department back to the private sector,
- Reduced the number of uninsured children in Kentucky; added 20,000 new children to Medicaid rolls,
- Increased collaboration will result in improved services for children,
- \$63 million in new dollars results in \$300 million in increased economic growth,
- Supports local health departments to increase technology access,
- Makes it easier to launch early childhood development initiatives,
- Including a higher FPL in the Medicaid expansion and adopting a Medicaid look-alike moved Kentucky to the “good list”, and
- Added excitement to government agencies.

**2. What lessons have we learned?**

***General Lessons Learned (List generated by critical leaders)***

- Integrating private health plans and public health plan may not be possible,
- Medicaid infrastructure is not easily replicated in private sector and vice versa,
- Need a more timely decision-making process,

Sometimes agencies work effectively “under fire,”  
Government forgives ‘miss starts’ if it means “doing the right thing,”  
Mass exodus from private health plans never became an issue,  
With time barriers can be overcome,  
Advantages exist to addressing uninsured population in stages with targeted groups,  
Can’t go where your market is not ready to go,  
We are capable of doing things differently,  
Program planning is dependent on environmental context,  
Need to confirm assumptions “*Because the devil is in the details,*” and  
Lessons from the past can help in the future.

***Attitudes***

- \*Some people still think it looks like welfare; are we removing stigma or hiding it?
- \*“If it is built, not everyone will come,”
- \*Staff and providers need to raise sensitivity levels,
- Moral boost for public agency employees when they can access KCHIP,
- We can provide for the uninsured,
- Some think KCHIP benefits are too generous, and
- We, the people, can make a difference.

***Data & Tracking Lessons (List primarily developed by stakeholders)***

Automated tracking is essential,  
HCFA wants lots of data,  
Timely tracking and data are essential, and  
Evaluation helps.

***Service Provider Lessons***

- \*Need adequate number of providers; insufficient provider network,
- \*Access to providers is important, especially dental care is an issue,
- Need incentive for the providers to participate, and
- Need to simplify process for providers.

***Outreach and Application Process Lessons***

- \*Effective outreach works/learned the importance of outreach,
- \*To publicize takes a LOT of money; money spent on advertising pays off,
- \*Combination of strategies are needed to get the word out and children enrolled,
- \*Need printed materials in Spanish,
- \*Advocates have significant influence,

Better job of “all” customer relations is needed,  
Evaluate the outreach message,  
Medicaid eligibility can be simplified,  
There are many barriers to enrolling children,  
Community collaboration is possible and results in successful outreach,  
Need to revisit the immigrant issue in terms of the message and staff training,  
Sell Medicaid as well as KCHIP, and  
Six-month waiting without insurance is a barrier.

***Implementation Lessons***

\*Simplicity is an asset/a Medicaid expansion was more expedient than a separate health insurance program,  
\*Education pays/information and education are essential to make a new program work, Confusion around the different phases/phases were too close together,  
Interaction is critical between policy makers and front-line workers,

***Similar functions can be performed by dissimilar agencies/all agencies must work together to get the job done,***

Agencies had to make KCHIP a priority,  
Coordinating with different agencies is difficult,  
Need to resolve issues faster,  
Education of eligibility workers is important,  
It is necessary to be flexible,  
Waiting period is a barrier,  
Evaluate budget and staffing needs as changes are made,  
Lack of federal rules require state flexibility,  
Long-standing procedures can be changed; perseverance pays,  
Need to staff new program,  
Appeals process is valuable,  
Co-payments and premiums are still an issue, and

***Benefit inequities still exist.***

3. What recommendations do you have for improving the KCHIP Program over the next two years?

The following is a prioritized list of the top fifteen recommendations that were identified by the focus groups. If items had the same number of points, they hold the same number; i.e., three items have a number two ranking.

- 1) Remove six-month waiting period,
- 2) Continue providing funds for outreach,  
KCHIP needs to improve internal & external communication between stakeholders,  
Simplify re-enrollment,
- 5) Assure funding is available to support the program and improvements,  
More DCBS eligibility workers are needed,  
Targeted recruitment of providers is needed,
- 8) Find ways to promote healthier lifestyles for children and families,  
Continue to look at issues surrounding presumptive eligibility,  
Provide adequate reimbursement for primary care providers and dentists,
- 11) Assess the KCHIP populations to improve health,  
Develop EBT Card,  
Develop member packet,  
Go higher than the 200% FPL, and
- 15) Establish electronic transfer of application.

03/30/00

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