

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS



**KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES**

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

Administrator
Health Care Financing Administration
7500 Security Blvd.
Baltimore, Maryland 21244

Attn: Family & Children's Health Programs Group
Center for Medicaid and State Operations
Mail Stop - C4-14-16

Re: Kansas State Child Health Plan Under Title **XXI** of the Social Security Act

Dear Madam:

Enclosed for review by HCFA staff is the Kansas Child Health Plan (original and ten (10) copies) which has been compiled in accordance with Title **XXI** of the Social Security Act. We are very pleased to be able to implement such a program for the citizens of our State. We look forward to working closely with your office in getting the Plan reviewed and approved.

Sincerely,

Rochelle Chronister
Secretary

cc: Joe Tilghman, Regional Administrator
Janet Schalansky, Deputy Secretary
JS:DJJD:bpl



KANSAS STATE CHILD HEALTH PLAN

**STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: KANSAS
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

7/2/98
(Signature of ~~G~~overnor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (**SCHIP**) (Section 2103); **OR**
- 1.2. Providing expanded benefits under the State's Medicaid plan (**Title XIX**); **OR**
- 1.3. A combination of both of the above.

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Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2101(a)(1)-(3) and (Section 2105)(c)(7)(A)-(B))

2.1 Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

US Census data indicates that there are a total of approximately 738,000 children ages 0-18 residing in the state of Kansas. Of those 738,000 children, approximately 326,000 live in families with annual income at or below 200% of the Federal Poverty Level. A September 1997 survey completed by the Kansas State Department of Health and Environment in cooperation with the University of Kansas shows that approximately 237,000 (72%) have health insurance coverage of some kind. Out of 115,270 children who are Medicaid eligible based on income, 100,000 are enrolled in Medicaid. Three thousand two hundred (3,200) children participate in the Caring program.

Based on the federally reported Current Population Survey (CPS) data, the following number of low-income uninsured children are estimated for the state of Kansas:

Uninsured Children by Age-Groups under 200% FPL

Age	0-99% FPL	100- 132% FPL	133- 149% FPL	150- 159% FPL	160- 169% FPL	170- 184% FPL	185- 199% FPL	Total
0				10	10	15	15	50
1-5			1,150	783	783	1,174	1,221	5,111
6-14		12,097	6,212	4,230	4,230	6,347	6,597	39,713
15-18		4,608	2,365	1,612	1,612	2,417	2,513	15,126
Total		16,705	9,727	6,635	6,635	9,953	10,346	60,000

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2.2. Describe the current state efforts to provide or obtain creditable coverage for uncovered children by addressing: (Section 2102)(a)(2))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Outreach and enrollment activities for Medicaid programs are administered through the Department of Social and Rehabilitation Services. Education regarding the Medicaid program is provided to advocacy groups, schools, health care professionals, social service agencies, and other community organizations who may have contact with children requiring health insurance coverage in an effort to enlist the help of these organizations in identifying children without health insurance coverage and assisting the families in making application for Medicaid. There are also staff located in local field offices and in Central Office who conduct public awareness and education activities for the Medicaid program. In addition, local field staff have out stationing duties at disproportionate shared hospitals and the Federally Qualified Health Centers in the State including Hunter Health Clinic (FQHC, IHS, & RHC) and United Methodist Health Clinic (FQHC) in Wichita. This provides additional opportunities for outreach and education as well as the initial processing of Medicaid applications.

Outreach activities for Maternal and Child Health and Title V programs are conducted through the Kansas Department of Health and Environment. Through an inter-agency agreement, SRS staff refer consumers potentially eligible for these programs to the appropriate agency for eligibility determination. KDHE staff also refer potential Medicaid eligibles to SRS.

2.2.2 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The state works cooperatively with the CARING Program for Children in providing education to **SRS** staff regarding the availability and program requirements for the program. Applicants for Medicaid who are found to be ineligible for benefits are referred to the CARING Program for potential eligibility determinations. CARING Program

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staff are also educated regarding eligibility criteria for Medicaid and refer potential eligibles to SRS.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102(a)(3))

The State's SCHIP program will be marketed as a health insurance program. The marketing program will include coordination of efforts with state and local governmental entities and other child serving agencies, including the:

- Kansas Department of Education
- local Unified School Districts
- Local Health Departments
- Kansas Insurance Department
- community based organizations, including Indian Health Clinics, providing services to American Indian children, and

Other local community programs that deal with families of potentially-eligible children including such traditional providers as:

- Head Start
- school-based clinics
- Women Infant and Children (WIC) programs
- Maternal Child Health (MCH) programs
- pre-schools
- child-care organizations
- parent-teacher associations
- religious organizations
- grass-root organizations
- other community-based organizations that deal with children.

The specific target audience of consumers will be:

- Low-income, Kansas families, up to 200% of the federal poverty level
- Families with uninsured children, 0-18 years of age, who are potentially eligible for the SCHIP or Medicaid Program
- Families with children with special health care needs
- Families without knowledge of, or access to, available health

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- care coverage for their children
- Potentially eligible youth, 16-18 years of age who may be living independently
- Schools, Local Health Departments, other governmental and private service agencies that interface with low income families
- Health care providers including hospitals, physicians, dentists, mental health providers and other providers of health care as directed by the SRS staff.

A single application form for both Title XIX and SCHIP will be used and made available at access points. In addition, a toll free 1-800 number will be established where interested persons can call for information and to request an application form. Applications will be self-addressed for return to a central processing unit. Once received at the central processing unit, the application will be reviewed for Title XIX eligibility first and referred as appropriate for final eligibility determination. If the applicant is found to be ineligible for Title XIX, then eligibility for SCHIP would be considered without requiring reapplication by the consumer.

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Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

Under the SCHIP Program, through the purchase of insurance, the Secretary will contract with such entities as determined appropriate to implement the health coverage plan in subsection (a) providing for several plan options to enrollees which are coordinated with federal and state child health care programs. Examples are, but not limited to insurance companies, health maintenance organizations, nonprofit dental service corporations, or nonprofit hospital and medical insurance corporations authorized to transact health insurance business in Kansas. Where feasible children shall have a primary care provider who shall coordinate their health care, including referrals to specialists, when appropriate. Insurers shall be chosen for participation in the program as a result of a competitive Request for Proposal (RFP) process. Insurers shall be selected in every geographic region of the State to assure statewide coverage.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

Utilization control mechanisms are in place for the SCHIP program to ensure that children use only health care that is appropriate, medically necessary, and approved by the State or the participating health plan.

Before being approved for participation in the SCHIP Program, health plans must develop and have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Plans also must develop procedures for identifying and correcting patterns of over and under utilization on the part of their enrollees.

More information can be found on utilization control in Section 7 - Quality and Appropriateness of Care.

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Section 4. Eligibility Standards and Methodology. (Section 2102(b))

Check here if the state elects to use funds provided under Title **XXI** only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

- 4.1.1 Geographic area serviced by the plan: The plan is available statewide.
- 4.1.2 Age: Children from birth to age 19 will be served.
- 4.1.3 Income: Income up to 200% FPL for the SCHIP program. Current Medicaid definitions of family income and those income deductions, disregards, and budgeting methods specified in the State's Title XIX State Plan will be applicable to the SCHIP population.
- 4.1.4 Resources (including any standards relating to spenddowns and disposition of resources): No resource test will be applied.
- 4.1.5 Residency: Children must be residents of Kansas. The citizenship and immigration status requirements applicable to Title XIX shall also be applicable to SCHIP.
- 4.1.6 Disability status (so long as any standard relating to disability status does not restrict eligibility):
- 4.1.7 Access to or coverage under other health coverage: Children are ineligible for SCHIP if currently covered by other health insurance or eligible for Medicaid coverage. In addition, children are also ineligible if they have been covered by health insurance in the previous six month period and such coverage was terminated without good cause.

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4.1.8 Duration of eligibility: Annual eligibility determination. Twelve months of continuous eligibility will also be applicable to both Title XIX and SCHIP even if family income increases above the income threshold.

4.1.9 Other standards (identify and describe):

- To be eligible for SCHIP coverage, families above 150% of the poverty level must agree to pay a monthly premium which will not exceed the limitations of section 2103(e).
- Children are ineligible for SCHIP coverage if they are eligible for health coverage under the Kansas Group Health Insurance Program, if they are an inmate in a public correctional institution, or if they are a patient in an institution for mental diseases.

4.2 The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B))

4.2.1 These standards do not discriminate on the basis of diagnosis.

4.2.2 Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3 These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 Describe the methods of establishing eligibility and continuing enrollment. (Section 2102(b)(2))

A simplified application/enrollment form will be used to access both Medicaid and SCHIP coverage. These forms will be available through a number of access points including schools, churches, medical providers, etc. The form

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will be mailed in along with supporting documentation such as wage information to a central clearinghouse. The clearinghouse will be responsible for initial processing and eligibility determination for both Medicaid and SCHIP and will involve privately contracted staff. The Medicaid state agency will administer the portion of the clearinghouse responsible for Medicaid determination and case maintenance. Contracted staff will be responsible for all SCHIP processing and determinations as well as ongoing case management. Both Medicaid and SCHIP cases will be maintained by the clearinghouse unless the family accesses other benefits such as food stamps or child care assistance. In these instances, the appropriate local SRS field office will manage the case, whether Medicaid or SCHIP related.

The Income Eligibility Verification System (IEVS) will be used to confirm income information on an ongoing basis and the Systematic Alien Verification for Entitlements (SAVE) program or an appropriate alternative will be used to verify immigration status.

Eligibility will be continuous for 12 months and re-established annually. The family must meet all eligibility criteria and have paid any applicable premiums from the prior year to be reenrolled for a new 12 month period.

Families will select their children's health plans after the eligibility determination is finalized. Where feasible the State plans to offer at least two health plans depending on the geographic area. The Medicaid Fiscal Agent will handle enrollment in the health plans.

4.4 Describe the procedures that assure:

4.4.1 Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102(b)(3)(A))

Most current Medicaid financial and non-financial requirements as specified in the Title XIX State Plan will be applicable to both the Medicaid and SCHIP populations. The central clearinghouse described in section 4.3 will determine initial eligibility for either Medicaid or SCHIP by reviewing income and other information submitted by families. Families will then be provided coverage under either Medicaid or SCHIP dependent upon total income available.

4.4.2 The children found through the screening to be eligible for medical

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assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102 (b)(3)(B))

Through the use of a combined simplified application/enrollment form and the central clearinghouse, eligibility will be determined for either Medicaid or SCHIP coverage based on income and age level.

4.4.3 That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102 (b)(3)(C))

The application/enrollment form will be used to ascertain current health insurance coverage as well as access to state employee coverage. Children found to have current health coverage will be denied eligibility for SCHIP coverage.

In addition, access to state employee coverage will result in denial of benefits under the SCHIP program.

Children who had health coverage within six months prior to application for the SCHIP program will be denied benefits unless such coverage was ended based on good cause. Good cause reasons would include such things as loss of employment due to factors other than voluntary termination, discontinuation of health benefits to all employees of the individual's employer, and termination of a health insurance plan the child was covered under by the insurer. Premiums will be charged to families above 150% of FPL in the SCHIP program.

The agency will undertake a review of the "crowd out" issue and monitor any conditions that may contribute to crowd out on at least an annual basis.

4.4.4 The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)). (Section 2102 (b)(3)(D))

The State will undertake the following actions:

- Include ethnic information on the application for tracking Indian numbers.
- Include, in the outreach media campaign and other outreach activities, the names of the community based organizations that serve Indian children, to assure that families are aware of the program and assist in the enrollment process.

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- Use of the three Indian Health Clinics as access points to provide enrollment materials and assistance to potentially eligible children.

4.4.5 Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102 (b)(3)(E))

The joint application process established for both Medicaid and SCHIP will help ensure coordination between the two programs and appropriate program coverage. A number of community based organizations will participate as access points to the program and provide enrollment materials and assistance. Other public program sites such as WIC agencies, FQHC's, local health departments, and KAN Be Healthy sites will also provide access to enrollment and help identify potentially eligible children. Children with special health needs will be served by the Medicaid and SCHIP programs and will be referred to appropriate programs such as Title V for services in addition to those provided through the Medicaid or SCHIP program.

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Section 5. Outreach and Coordination (Section 2102(c))

5.1 Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program:

SCHIP materials will be developed and distributed. The SCHIP program will be named and a logo will be developed. The public school setting will be the main, but not sole, focus of outreach to families. Information will be available at school registration to all families and a special effort will be made to reach those families who qualify for free or reduced school lunch. Outreach sites and enabling services will include, but are not limited to, implementation of a tollfree number for enrollment information, community outreach workers, public service announcements, inserts in utility bills, Indian Health Services, Head Start, early childhood intervention sites, local and rural health departments, WIC clinics, hospital emergency rooms and pediatric units, physician offices and other outlets to be identified by the state and other affected entities. The clearinghouse, or other contractors, will assist in providing outreach efforts.

5.2 Coordination of the administration of this program with other public and private health insurance programs.

At the time of application, the application will be reviewed to identify other public or private health insurance programs for which the child and their family may qualify or already have coverage. Through the joint simplified application process Kansas is coordinating the eligibility process for Title XIX and Title XXI.

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Section 6. Coverage Requirements for Children’s Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.)

6.1.1. Benchmark coverage; (Section 2103(a)(1))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

State employee standard HMO coverage (all HMO’s participating in the state employee health plan must cover a standard package of benefits).

6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.) _____

6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.

6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If “existing comprehensive state-based coverage” is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for “existing comprehensive state-based coverage.” _____

6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))

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6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))

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- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services (Section 2110(a)(17))
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

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The amount, duration and scope of services listed in Section 6.2 is defined in the attachment.

6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1. **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i))

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

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6.3.2. **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3))**

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)**
(Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B))**

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Section 6
Attachment A

OVERVIEW OF THE BENEFITS SCHEDULE

The Kansas State Children’s Health Plan will be known as HealthWave.

Copayments and Deductibles

No copayments or deductibles may be charged to HealthWave members for any of the three service categories, Physical Health Services, Behavioral Health and Substance Abuse Services, and Dental Services listed below. HealthWave members may be liable for the cost of services not covered under this contract, or for the cost of services obtained without following approved prior authorization procedures.

Medical Necessity: In addition to the basic benefits package below, contractors must provide all medically necessary services to children insured by this program. Determination of medical necessity may be made on a prior authorization, concurrent or post-utilization basis, must be in writing and must be based upon the following standards, the satisfaction of which will result in authorization of the service:

- i) the service or benefit is necessary to prevent the onset of an illness, condition or disability;
- ii) the service or benefit is necessary to reduce or ameliorate the effects of an illness, injury, disability, disorder or condition;
- iii) the service or benefit will aid in the individual’s overall physical and mental growth and development;
- iv) the service will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

Determinations of medical necessity shall be based on information provided by the individual’s primary care provider, as well as any other providers, programs and agencies that have evaluated the child.

PHYSICAL HEALTH SERVICES

Physician Services

Physician services shall include: Diagnostic and treatment services by participating physicians and other participating health professionals; including office visits; periodic health assessments including school and camp physicals; hospital care; consultation; manipulation; surgical and non-surgical office

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Section 6
Attachment A

procedures and injectable medications administered by the physician or medical staff under direction of the physician

Outpatient Services

Outpatient services shall consist of all services requested or directed by the Contractor, or primary care physicians to be provided on an outpatient basis, including diagnostic and/or treatment services; health evaluations, well-child care and routine immunizations according to Centers for Disease Control (CDC) guidelines; drugs administered in an outpatient setting, prescription medications, biologicals, and fluids; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, the administration of blood and blood products, recovery room services, ambulatory surgical centers, and hospital outpatient surgical centers.

Inpatient Hospital Services

Inpatient Hospital Services will be provided upon prior approval of the Contractor, for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or on an outpatient basis. Hospital Services shall include semi-private room and board; care and services in an intensive care unit; administered drugs, prescribed medications, biologicals, fluids and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; the administration of blood and blood products; x-rays, laboratory and other diagnostic services; anesthesia and oxygen services; inhalation therapy, radiation therapy; and such other services customarily provided in acute care hospitals.

Inpatient Services at Other Participating Health Care Facilities

A Participant shall be entitled to inpatient services at Other Participating Health Care Facilities for a minimum of sixty (60) days per Contract Year, when medically appropriate as determined by the Contractor. Services shall include semi-private room and board; care and services in an intensive care unit; administered drugs, medications, biologicals, fluids and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; the administration of blood and blood products; x-rays, laboratory and other diagnostic services; anesthesia and oxygen services; inhalation therapy, radiation therapy; and such other services customarily provided in acute care hospitals.

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Short-Term Rehabilitative Therapy

Short-term rehabilitative therapy, including physical, speech and occupational therapy, will be provided on an inpatient or outpatient basis. Services provided on an outpatient basis will be a minimum of one hundred eighty (180) consecutive days per condition if significant improvement can be expected within sixty (60) days of the first treatment, as determined by the Contractor. Contractor may conduct periodic evaluations as required to assure continued medical necessity. Such coverage will be available only for rehabilitation following injuries, surgery or acute medical conditions.

Home Health Services

Home health services will be provided for a participant who requires skilled care and is home bound due to a disabling condition, is unable to receive medical care on an ambulatory outpatient basis, and does not require confinement in a hospital or other participating health care facility. Home health services shall be provided by an accredited home health agency which is a participating provider. Home health services include visits by professional nurses and other participating health professionals (including home health aides), consumable medical supplies and durable medical equipment administered or used by such persons in the course of services rendered during such visits, medical social services for the terminally ill, and drugs administered in the home setting which are prescribed by a participating provider and which are covered under the plan. Physical, occupational and speech therapy provided in the Home will be subject to the benefit limitations described under "Short-Term Rehabilitative Therapy".

Diagnostic Laboratory and Diagnostic and Therapeutic Radiology Services

Diagnostic laboratory and diagnostic and therapeutic radiology services shall include electrocardiograms; electroencephalograms; radiation therapy; Computer Hided Tomography (CAT) scans, Magnetic Resonance Imaging (MRI) procedures, and other diagnostic and therapeutic procedures.

Maternity Care

Maternity care shall include medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

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Family Planning Service Access and Confidentiality

Family Planning Services are a covered benefit. Examples of family planning and reproductive health services are: contraception management, insertion and removal of Norplant, insertion and removal of IUD, Depo Provera Injections, Pap test, pelvic exams, sexually transmitted disease testing, family planning counseling/education or various methods of birth control.

Services for Infertility

Infertility services will be covered as determined by the Contractor. These include diagnostic services to establish cause or reason for infertility. Artificial Insemination will be covered subject to a maximum of three billable attempts per year of eligibility subject to prior authorization by the Contractor. There is no coverage for donor fees, collection and/or storage of sperm or any other related services.

Vision Services

Vision Services will be covered. These services include one complete eye exam, one pair of glasses including frames and lenses as needed, and repairs as needed, for members, Eye exams for post-cataract surgery patients up to one year following the surgery and eyeglasses for post-cataract surgery members will be covered when provided within one year following surgery. Contact lenses and replacements will be covered when ordered by a qualified Contractor provider and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses.

Eye prosthesis includes postsurgical lenses customarily used during convalescence from eye surgery, will be covered when ordered by a qualified Contractor provider.

Ambulance Service

A Participant will be entitled to ambulance service, provided such ambulance service is Medically Necessary and authorized by the Contractor, or the use of such ambulance service is determined to have been an Emergency Service, as defined in the "Emergency Services" provision below.

Prescribed Drugs

A Participant will be entitled to prescribed drugs as defined below. Bidders must propose their Prior Authorization (PA) List. Future PA additions must be prior approved by **SRS**.

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Plan Design:

Formulary: Open

Quantity/Days Supply: 34-day supply or less (one standard quantity)

Refills: available after 75% of the original supply has been consumed

Prior Authorization may include, but is not limited to: growth hormone, amphetamines/amphetamine mixtures, Accutane, Retin-A

Maximum allowable quantity list: -- must be included in the Vendor's Proposal.

EXCLUSIONS :

- Drugs for cosmetic purposes
- Drugs available without a prescription, except insulin, acetaminophen, ibuprofen, multivitamins, oral electrolyte solutions (such as Pedialyte), cough and cold preparations.
- Appetite suppressants, anorexiant or diet aids
- Experimental or investigational drugs
- Drugs not registered with the FDA or that do not have FDA approved indications
- Drugs furnished by local, state or federal government and any drug to the extent payment of benefits are provided or available from local, state or federal government whether or not that payment or benefit is received, except as otherwise provided by law.
- Replacement prescription drugs resulting from loss or theft.

Emergency Services

1. Definition of Emergency Services. Services which would be considered emergent by an individual, without medical knowledge, must be covered under the Contract as required by the Federal Balanced Budget Act of 1997.
2. Emergency Services Within the Service Area. Emergency Services within the Service Area must be obtained from the Primary Care Physician or other Participating Providers. Participating Providers must be available on call twenty-four (24) hours a day, seven (7) days a week, to assist Participants needing Emergency Services. Emergency Services obtained other than as set forth above will be covered only if the Contractor, on review, determines that the Participant had no control over where or by whom the Emergency Services were rendered.
3. Emergency Services Outside the Service Area. Participants will be covered for Emergency or

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urgent care services outside the Service Area. Participants must contact the Contractor covering the required emergency service immediately for direction and authorization; however, this requirement shall not cause denial of an otherwise valid claim if the Participant could not reasonably comply, provided that notification is given to the Contractor as soon as reasonably possible. The Contractor, at its option, may arrange to transfer a Participant to a Participating Provider for continued care when medically prudent to do so.

4. Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, will not be covered unless authorized in advance by the Primary Care Physician or the Contractor.

Internal Prosthetic/Medical Appliances

Coverage for Internal Prosthetic/Medical Appliances authorized by the Primary Care Physician consists of permanent or temporary internal aids and supports for defective body parts. Repair or maintenance of a covered appliance will be covered. Prosthetic devices will be limited to the first surgically implanted device and the first ocular or prosthesis required as a result of accidental injury. The plan will cover artificial limbs only to the extent of the first such artificial limb required. Special braces required to maintain the function of a disabled limb or required to support a functionally impaired body part. Penile implants only when required as a result of diabetes or other medical conditions. There will be a maximum of one implant per lifetime which is a covered benefit unless the prosthetic device or appliance is no longer suitable due to continued growth and/or development, providing the original prosthetic device or appliance was originally provided to a child.

Breast Reconstruction and Breast Prostheses

Incidental to a mastectomy, the Participant shall be provided surgical services for breast reconstruction and up to two (2) external post-operative breast prostheses.

Durable Medical Equipment

Durable Medical Equipment, including medical supplies and equipment, which include those necessary for the administration of insulin; and asthma supplies such as, but not limited to, spacers, nebulizers, peak flow meters will be covered when deemed necessary and ordered by the primary care physician.

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Organ Transplant Services

A Participant will be entitled to receive benefits for human organ and tissue transplant services , at limited facilities throughout the United States, as designated by the Contractor, subject to the conditions and limitations below.

1. Definition of Transplant Services. Transplant services are the recipient's medical, surgical and hospital services, inpatient immunosuppressive medications, and organ procurement required to perform the following human to human organ or tissue transplants: kidney, cornea. Other tissue or organ transplants; bone marrow, heart, heart/lung, liver or pancreas, shall be reimbursed on a fee-for-service basis (inpatient hospital service costs only) with prior approval of SRS. The Contractor shall cover all non-inpatient costs associated with these transplantation services.

2. Preauthorization. Coverage for transplant services must be authorized by the Contractor based on the medical criteria and methodology employed by a transplant facility designated by the Contractor.

Nutritional Evaluation

Initial nutritional evaluation and counseling from a Participating Provider will be provided when diet is part of the medical management of a documented disease, including morbid obesity.

Hospice Services

Hospice Care Services when provided, due to Terminal Illness, under a Hospice Care Program will be covered. Hospice Care Services shall include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; bereavement counseling once every six weeks, and Home Health Services.

Hospice Care Services do not include the following:

- services or supplies not listed in the Hospice Care Program;
- services for curative or life prolonging procedures;
- services for which any other benefits are payable under the Contract;
- services or supplies that are primarily to aid the Participant in daily living in excess of 10 days per month;
- services for respite care;
- nutritional supplements, non-prescription drugs or substances, medical supplies vitamins or minerals.

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Oral Surgery Benefits

Benefits for Oral Surgical Procedures of the jaw or gums will be covered for;

1. Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
2. Removal of exostoses (bony growths) of the jaw and hard palate;
3. Treatment of fractures and dislocations of the jaw and facial bones;
4. Intra-oral X-rays in connection with covered oral surgery if treatment begins within 30 days.
5. General anesthetic for covered oral surgery.

Anti-hemophiliac factors:

Vaccine Purchases: MCOs are encouraged to coordinate with Kansas Immunization Program Providers in MCO covered regions to facilitate the Immunization Program. MCOs should encourage their network providers not currently participating in the Vaccines for Children program to apply to become Kansas Immunization Program Providers by completing the "Vaccines For Children" (VFC) Program 1998 Provider Enrollment Form.

The following vaccines are available in the Vaccines For Children Program. Contractors will be notified of any changes to this list of available vaccines.

Vaccines included in the CDC Recommended Childhood Immunization Schedule 1998

- Diphtheria, Tetanus, acellular Pertussis (DtaP)
- Diphtheria, Tetanus, Pertussis (DTP)
- Diphtheria, Tetanus toxoid combined (DT)
- Tetanus, Diphtheria toxoid combined (Td)
- Haemophilus influenza type B (HIB)
- Haemophilus influenza type B, Hepatitis B comb. (HIB/HepB)
- Polio Virus, live, oral (OPV)
- Polio Virus, inactivated (IPV)
- Measles, Mumps, Rubella (MMR)
- Hepatitis B, pediatric, birth - 10 years (Hep B ped)
- Hepatitis B, high risk, 11 - 18 years (Hep B high risk)
- Hepatitis B, adult (Hep B, adult);
- Varicella Virus Vaccine (Var)

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The following vaccines if indicated:

- Hepatitis A (Hep A)
- Influenza Virus (Flu)
- Pneumococcal (Pneumo)

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

Inpatient and Outpatient Behavioral Health Services

Coverage of medically necessary inpatient and outpatient mental health/behavioral health services for “biologically based” mental illnesses is a requirement under this Contract. For the purpose of this Contract “biologically based” means the following:

- a. Schizophrenia, schizo affective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis;
- b. major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders;
- c. obsessive compulsive disorder;
- d. panic disorder
- e. pervasive developmental disorder, including autism;
- f. other childhood mental illnesses, including attention deficit disorder and attention deficit hyperactive disorder; or
- g. borderline personality disorder.

Substance A-use Services

Inpatient:

Coverage will be provided for up to sixty (60) days per plan year, when medically necessary, for rehabilitation when required for diagnosis and treatment of abuse or addiction to alcohol or drugs upon authorization by the Contractor or its designee. Inpatient services will be covered only if provided by a facility designated by the Contractor.

The benefits may be exchangeable with partial hospitalization sessions, if medically necessary and appropriate, of not less than three (3) hours and not more than twelve (12) hours in any twenty-four (24) hour period, based upon the following exchange formula: If the charge for one partial hospitalization session does not exceed fifty (50) percent of the allowable charges for one inpatient day of the average semi-private rate at the Participating Hospital where the session is conducted, the benefit exchange shall be two (2) partial hospitalization sessions equal to one day of inpatient care. If the charge for one partial hospitalization session does not exceed fifty (50) percent of the allowable charges for one

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inpatient day for the average semi-private rate at the Participating Hospital where the session is conducted, the benefit exchange will be one partial hospitalization session equal to one day of inpatient care.

Outpatient: Up to twenty-five (25) visits per plan year. Group therapy sessions count as 1/2 of an individual session.

Detoxification Services: Coverage will be provided for detoxification and related medical ancillary services when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. The Contractor will decide, based upon medical necessity, whether such services are provided in an inpatient or outpatient setting.

DENTAL SERVICES

Coverage for preventative and necessary dental benefits is a requirement under this Contract. The Contractor providing dental management services shall cover the following dental care services:

Diagnostic: Includes procedures necessary to assist the dentist in evaluating existing conditions and the dental care required.

Oral examinations twice per plan year not to exceed one every four months

Diagnostic x-rays; bitewings twice per plan year not to exceed one every four months for dependents under age 18 and once every twelve months for adults age 18 and over.

Full mouth x-rays once every five years.

Preventive: Provides for the following:

Prophylaxis/cleaning (including periodontal maintenance) twice per plan year not to exceed one every four months

Topical fluoride twice per plan year not to exceed one every four months

Space maintainers only if under age 9 for premature loss of primary molars

Sealants one per four years for children under age 17 for permanent molars with no decay or restorations.

Ancillary: Provides for visits to the dentist for the emergency relief of pain

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Oral-surgery: Provides for extractions and other oral surgery including pre- and post-operative care.

Regular Restorative Dentistry: Provides amalgam, synthetic porcelain and composite white resin restorations on front teeth.

Endodontics: Includes necessary procedures for root canal treatments and root canal fillings.

Periodontics: Includes procedures necessary for the treatment of diseases of the gums and bone supporting the teeth.

Special Restorative Dentistry: When teeth cannot be restored with a filling material listed under Regular Restorative Dentistry, provides for gold restorations and individual crowns. Buildup and pins covered if tooth had a previous root canal treatment.

TMJ: Limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction.

Prosthodontics: Includes bridges, partial and complete denture, including repairs and adjustments.

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Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

The state will use quality standards, performance measurements, information strategies, and quality improvement strategies to achieve the goals established with the implementation of managed care as a delivery system for SCHIP. The following definition of quality of care will guide quality management.

“Quality care achieves the best possible health outcomes and functional health status by delivering the most appropriate level of care in a safe environment, with the least possible risk. Quality care is accessible and efficient, provided in the appropriate setting, according to professionally accepted standards, in a coordinated and continuous, rather than episodic, manner.”

Goals underlying the implementation of this quality care are:

To improve the quality of services provided to the SCHIP population.

A central component of the quality management program is the ongoing evaluation of the provision of care and the measurement of key outcomes related to specific conditions or diagnoses important to the SCHIP population.

To improve consumer access to health care.

The quality management program includes specific access standards which address access to providers, appointments, maximum distance and other structural measures of access to care. Evaluation of outcomes will focus on access to primary care services.

Ensure and protect consumer rights and dignity.

Consumers are provided a written copy of specific program rights and responsibilities upon enrollment. A consumer survey is sent one time per year to assess consumer satisfaction.

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EXTERNAL MONITORING

Peer Education

A peer education and resource council will be utilized to provide clinical consultation and education for primary care providers and SRS. It will also develop and recommend policy initiatives to SRS to enhance quality of care and access to services for beneficiaries while controlling costs. The responsibilities include (but are not limited to) the following:

- A. Complete research and analyze studies to determine trends and patterns.
- B. Create provider corrective action plans.
- C. Provide expertise in clinical and non-clinical areas.
- D. Define standards of practice to be used for the program and provider evaluation.

Drug Utilization Review (DUR)

A board of health care professionals will be responsible for retrospective and prospective drug utilization review. The group will use a computerized decision support system to analyze paid claims, performing retrospective DUR, pharmacy outcomes-based studies, and monitoring prospective DUR indicators. Education of pharmacists and physicians is accomplished through a newsletter and through individual letters addressing various drug utilization issues.

External Quality Review Organization (EQRO)

The EQRO will perform on a periodic basis, a review of the quality of services furnished by each managed care contractor. External quality review includes three types of activities: focused studies of patterns of care; individual case review in specific situations; and follow-up activities on previous pattern of care study findings and individual case review findings. This will provide the SRS and federal government with an independent assessment of the quality of health care delivered to SCHIP beneficiaries enrolled in contracting HMOs. The EQRO will work to resolve identified problems in health care and contributes to improving the care of all SCHIP beneficiaries. The EQRO will work closely with the State and contracting HMOs to insure workable implementation of external review

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EQRO Advisory Committee (EQRO AC)

The Advisory Committee will be composed of medical directors and quality improvement staff of contracting HMOs, SRS Adult and Medical Services staff and EQRO medical and clinical staff. The committee will evaluate data and select topics for quality management studies done by contracting HMOs. It will recommend indicators and data collection methodology. EQRO AC will review collected data, develops interventions and assist with implementing these interventions to improve the health care delivered to SCHIP beneficiaries enrolled in contracting HMOs.

INTERNAL MONITORING

Contract Compliance Review

Each of the contracts between SRS and participating health, dental and vision plans will contain specific performance objectives. SRS will monitor contracting HMOs, on a periodic basis, to determine compliance with these performance objectives. Areas to be monitored include, but are not limited to:

- The HMO's complaint/grievance policies and procedures
 - The policies and procedures used by the HMO to safeguard confidential information
 - The contents and scope of HMO contract with practitioners
 - Coordination and continuity of care
 - The HMO's credentialing process
- The HMO's denial policies
 - The scope of the HMO's member service effort, including health education and prevention programs
 - Enrollment/disenrollment policies and procedures
- Medical records policies and procedures, accessibility and availability
- Provider network and access to covered services
- The HMO's organizational structure and administration to monitor and evaluate the care delivered to enrollees
 - The HMO's process to survey members and providers

Complaint and Grievance Review

Complaint is a minor verbal or written expression of concern about a condition with the provider, consumer or other person which may be resolved on an informal basis.

Grievance is a more serious written expression of concern about the provider's operation or a complaint which has not been resolved to the provider's satisfaction.

Both situations require formal written documentation. A thorough investigation will be

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made and appropriate resolution presented to the consumer.

All calls and letters from members will be received in the customer service unit. Every inquiry (calls or letters) will be logged. Once the inquiry is logged, it is evaluated to determine if the inquiry should be handled by professional medical staff.

Professional medical staff will receive complaints regarding utilization, quality of care, and access. Each inquiry will be researched thoroughly and responded to. Clinical education will be given to members by this staff.

Policy Evaluation

The policy evaluation unit will conduct routine examination of data to monitor access, utilization and quality of care issues on a regional basis, by providers, and for targeted demographic groups.

Utilization and Review Studies

Research studies will be requested from providers and reviewed on an annual basis. The findings will be used to make program change recommendations.

7.1.1. **Quality standards**

Tools to assure quality will include:

- Written provider credential standards.
- Written descriptions of quality standards
- Annual audits of plan compliance
- Process to survey consumers and providers

7.1.2. **Performance measurement**

Tools to measure performance will include:

- Well-child screening rates
- Immunization rates
- Responses to satisfaction surveys
- Prenatal care compliance
- Primary care visit rates

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7.1.3. **Information strategies**

Tools to measure information strategies will include:

- Review of enrollment materials
- Consumer and Provider advisory groups
- Periodic community meetings
- Survey results
- Complaint and grievance results

7.1.4. **Quality improvement strategies**

Tools to monitor quality improvement strategies will include:

- Corrective action plans
- Compliance audits
- Review of utilization rates

7.2. **Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))**

Methods to ensure access include, but are not limited to the following:

- Monitoring of numbers of various providers in each county.
 - Study of twenty four hour seven day a week accessibility on a random basis.
 - Studies of waiting times - offices, hospital ER, and clinics.
- Monitoring of enrollment, and disenrollment reports.
 - Monitoring of complaints and grievances.
 - Study of availability of transportation services.
 - Study of distance and travel time between providers and consumers
 - Consumer satisfaction surveys.
 - Study of emergent and non-emergent patterns of ER usage.
 - Study of appointment time (office, urgent, emergent) scheduling.

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Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. YES

8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income: (Section 2103(e)(1)(A))

8.2.1. Premiums:

151% of poverty to 175% of poverty shall be \$10.00 per month per family.
176% of poverty to 200% of poverty shall be \$15.00 per month per family.

8.2.2. Deductibles: None

8.2.3. Coinsurance: None

8.2.4. Other: None

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

Outreach materials will be designed to notify potential applicants of premium payments applied to families with incomes above 150% FPL.

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

8.4.2. No cost-sharing applies to well-baby and well-child care, including age - appropriate immunizations. (Section 2103(e)(2))

8.4.3. No child in a family with income less than 150% of the Federal

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Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

- 8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
 - 8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
 - 8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. (Section 2105(c)(6)(A))
 - 8.4.7. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))
 - 8.4.8. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B))
 - 8.4.9. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105(c)(7)(A))
- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))

Families will be notified of premium amount based on reported family income at time of each annual enrollment. Premiums charged for coverage of children above 150% of the poverty level do not exceed 1% of the total family income. Premiums may be reduced or eliminated based on reported decreases in income during the year.

- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:
- 8.6.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

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- 8.6.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)).

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Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

- 9.1. **Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2))**
1. Reduce the number of uninsured non-Medicaid eligible children under 19 years of age and below 200% FPL in the State of Kansas.
 2. Prevent a crowd-out of employer-based health insurance for employees with SCHIP-eligible children.
 3. Assure that the enrolled children with significant health needs have access to appropriate care.
 4. Assure that the enrolled children receive high quality health care services.
 5. Increase the percentage of enrolled children with regular preventive care.
- 9.2. **Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))**

Strategic Objective #1

Performance Goal: By December 31, 1999, at least 30,000 previously uninsured non-Medicaid eligible children will be enrolled in the SCHIP program. Another 10,000 children per year will be enrolled in years 2000 and 2001.

Performance Measure: The enrollment data and Current Population Survey (CPS) data.

Strategic Objective #2

Performance Goal: Maintain the proportion of children under 200% Of the FPL who are covered by employer-based health insurance.

Performance Measure: The enrollment data for SCHIP, Medicaid and CPS data.

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Strategic Objective #3

Performance Goal: Reduce the number of cases of hospitalization due to asthma among the enrolled children.

Performance Measure: Number of hospitalizations due to asthma. This will be measured from administrative/claims data for hospital stay and services.

Strategic Objective #4

Performance Goal: By December 31, 2000, at least 90% of SCHIP enrollees will report overall satisfaction with their health care.

Performance Measure: Consumer Assessment of Health Plans Study (CAHPS) survey results.

Strategic Objective #5

Performance Goal #1: By December 31, 1999, at least 75% of enrolled children through 2 years of age will receive one or more age-appropriate immunizations.

Performance Measure: Health Plan Employer Data and Information Set (HEDIS) data.

Performance Goal #2: By December 31, 1999, at least 80% of enrolled children will receive one or more Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

Performance Measure: HCFA-416 report

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B))

Please see Section 9.2 above.

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Check the applicable suggested performance measurements listed below that the state plans to use:
(Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well child care
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, please list: _____
- 9.3.8. Performance measures for special targeted populations.
- 9.4. The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1))**

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**9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state’s plan for these annual assessments and reports. (Section 2107(b)(2))
Section 9.5**

The state will perform the annual assessments and evaluations required in Section 2108(a) to assess its progress in meeting the performance goals and measures identified in Section 9. The assessments will be based on data drawn from the MMIS database, the Current Population Survey (CPS) by the US Census Bureau, other surveys carried out by third party contractors, and the HEDIS reports.

The following levels of aggregation describe the various ways information and reports will be presented or formatted to individuals within SRS and the State system who will be involved with the management or evaluation of the SCHIP program. Information will be produced at various levels of aggregation to match the audience who receives the information. There are three levels of aggregation:

- Executive reporting
- e Management data reporting
- e Program/operational implementation data reporting

Executive reporting contains very high level, broad information sufficient to indicate the overall performance of the program. Users of this type of reporting would include the Governor’s office, the Secretary of SRS, Legislature, Statewide Implementation Committee, and the AMS Commissioner’s office.

Management data reporting contains more detailed information than the executive reporting and will present standards or benchmarks that will allow a comparative analysis. The primary users for this level of information are Division Directors within AMS and Managed Care Team Leaders. The management data reporting will consist of separate graphical reports for each component: access, quality, fiscal, and program operations. To facilitate the comparison between performance and desired goal or standard, the report will display actual performance data and the established parameters for the standard.

Program/operational implementation data reporting will contain detailed information on each area and comparative information as in the management

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data reporting level. In addition, it will identify specific factors that may contribute to the results on the report. The users of this level of information would include: Program Managers, HMO Program Managers, Primary Care Case Managers, and Primary Care Physicians. Some program/operational implementation data reports will be graphical, and others will be the more traditional data tables and matrices.

Reports necessary for the annual assessment and evaluation will entail a compilation of reports from each of the levels.

- 9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))
- 9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e))
- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(I) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1115 (relating to waiver authority)
- 9.8.5. Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6. Section 1124 (relating to disclosure of ownership and related information)

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- 9.8.7. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. Section 1128A (relating to civil monetary penalties)
- 9.8.9. Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10. Section 1132 (relating to periods within which claims must be filed)

9.9 Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107 (c))

The state of Kansas had two task forces that looked at the development and the design of the State Children's Health Insurance. The Department of Social and Rehabilitation Services, Commission of Adult and Medical Services formed the task force named the Kansas Insurance Coverage for Kids (KICK). The Insurance Commissioner also formulated a task force. Both task forces met separately, but there were persons that were members of both task forces. The task forces began their work on August 22, 1997. Each task force met 4 times. The task forces had representatives from: Caring Project/BCBS, HCFA, HealthNet, CEO Mercy Hospital, Kansas Chamber of Commerce and Industry, Heartland Health Network, County Health Department, Children's Alliance, KU Medical Center, Kansas United

Methodist Health Ministry Fund, Blue Advantage Plus, Kansas State Nurses Association, FQHC, Kansas Medical Society, Pharmacy, Kansas Association for the Medically Underserved, Kansas Hospital Association, Kansas State Department of Health and Environment, Kansas State Department of Education, Kansas Department of Social and Rehabilitation Services, Kansas State Department of Administration, Kansas Insurance Department, Health Insurance Association of America, Partnership for Children, Kansas Action for Children, Coffey Health System, Kansas Health Institute, KU School of Nursing, Kansas Children Service League, Blue Cross Blue Shield of Kansas, Kansas Employer

Coalition of Health, and a state Representative and Senator. The task forces had multiple news articles published statewide, and media coverage over their meetings.

These two task forces collaborated to form the following guiding principles for Title XXI:

- Reach all children under 200% of federal poverty level with quality health care to improve the health status of children in Kansas. This means a focus on education

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- and outreach programs, utilizing existing community organizations, schools, etc.
- Create a program that is sustainable with the expansion funding from the federal government (Title XXI);
- Be innovative;
- Reduce the complexities of the current Medicaid program.

The two task forces combined efforts to form the implementation work groups. These work groups are: Marketing, Education and Training, Provider Training, Eligibility, Systems, State Plan, Benefits, Actuarial Rates, Finance, Quality, and Conversion. The implementation work groups began their work in December of 1997 with the goal of full implementation of Title XXI on January 1, 1999. The work groups membership consists of the above list with the addition of representatives from the Community Mental Health Centers. As the workgroups have proceeded with their work invitations have been issued to other stakeholders to become a part of the implementation workgroups. Some of these stakeholders are the dental association, and state school nurses associations.

The Kansas program will continue to inform the general public about the SCHIP program through mixed media, public service announcements, and other sources that are identified. Through these avenues, persons will be encouraged to become involved or informed in the effort to insure the medically uninsured children of Kansas.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for states to utilize

See Attachment A

CHILDREN'S HEALTH INSURANCE PROGRAM BUDGET REPORT
FOR THE TITLE XXI PROGRAM
STATE EXPENDITURE PLAN

STATE: KANSAS
AGENCY: SOCIAL & REHAB SERVICES
SUBMISSION DATE: MAY 15, 1998

FISCAL YEAR AND QUARTER	TOTAL COMPUTABLE	FEDERAL SHARE	STATE SHARE
	A	B	C
FISCAL YEAR (1) 1998			
1. QUARTER 1			
2. QUARTER 2			
3. QUARTER 3			
4. QUARTER 4	42,910,733	30,809,906	12,100,827
5. TOTAL	42,910,733	30,809,906	12,100,827
FISCAL YEAR (2) 1999			
6. QUARTER 1	750,000	538,500	211,500
7. QUARTER 2	1,500,000	1,077,000	423,000
8. QUARTER 3	3,000,000	2,154,000	846,000
9. QUARTER 4	37,660,733	27,040,406	10,620,327
10. TOTAL	42,910,733	30,809,906	12,100,827

I CERTIFY THAT

- THE BUDGET ESTIMATES ARE ONLY PROVIDED FOR ALLOWABLE EXPENDITURES FOR THE CHILDREN'S HEALTH INSURANCE PROGRAM UNDER TITLE XXI IN ACCORDANCE WITH APPLICABLE SECTIONS OF THE SOCIAL SECURITY ACT, IMPLEMENTING TITLE XXI REGULATIONS, AND OUR APPROVED TITLE XXI STATE PLAN
- THE BUDGET ESTIMATES ARE BASED ON THE MOST RELIABLE INFORMATION AVAILABLE TO THE STATE
- THE AMOUNT OF STATE AND LOCAL FUNDS AVAILABLE FOR THE QUARTER BEGINNING _____ FOR THE TITLE XXI PROGRAM IS _____
- I AM THE EXECUTIVE OFFICER OF THE STATE AGENCY CHARGED WITH THE DUTIES OF ADMINISTERING (OR SUPERVISING THE ADMINISTRATION OF) THE STATE PLAN

NOTE: Estimates include administrative costs equal to 10% of total estimates (\$4,291,073 each year, \$3,080,991 Federal, \$1,210,082 state) For each capitated claim, \$2.17 is paid to the fiscal agent. The remainder will be used for clearing house costs (marketing, outreach, and enrollment) and state administrative costs.

DATE _____ / SIGNATURE _____ TITLE _____

FORWARD COMPLETED FORM TO THE HEALTH CARE FINANCING ADMINISTRATION, CENTER FOR MEDICAID AND STATE OPERATIONS, QPMG, DIVISION OF FINANCIAL MANAGEMENT MAIL STOP C4-18-27 7500 SECURITY BLVD BALTIMORE, MD 21244-1850

FORM HCFA-21B

MAILING ADDRESS: HEALTH CARE FINANCING ADMINISTRATION
ROOM 281 EAST HIGH RISE, P.O. BOX 26678,

STATION, MARYLAND
RE. MARYLAND DIVISION OF FINANCIAL MANAGEMENT
7-0 78

Section 9
Attachment A

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Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2))**

- 10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

- 10.1.2. Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

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Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

<u>Attributes of Population</u>	<u>Number of Children with Creditable Coverage</u>		TOTAL
	<u>XIX</u>	<u>OTHER CHIP</u>	
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
<u>Age</u>			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
<u>Race and Ethnicity</u>			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
<u>Location</u>			
MSA			
Non-MSA			

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- 10.2. State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**
- 10.2.1. An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
- 10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:
- 10.2.2.1. The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
- 10.2.2.2. The quality of health coverage provided including the types of benefits provided;
- 10.2.2.3. The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4. The service area of the state plan;
- 10.2.2.5. The time limits for coverage of a child under the state plan;
- 10.2.2.6. The state's choice of health benefits coverage and other methods used for providing child health assistance, and
- 10.2.2.7. The sources **of** non-Federal funding used in the state plan.
- 10.2.3. An assessment of 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.

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- 10.2.4. A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. Recommendations for improving the program under this Title.
- 10.2.8. Any other matters the state and the Secretary consider appropriate.
- 10.3. The state assures it will comply with future reporting requirements as they are developed.
- 10.4. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

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