



**KANSAS DEPARTMENT OF SOCIAL  
AND REHABILITATION SERVICES**

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

**ROCHELLE CHRONISTER, SECRETARY**

August 27, 1998

Administrator  
Health Care Financing Administration  
7500 Security Boulevard  
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 is the official response to questions posed by the Health Care Financing Administration (HCFA) in reference to the Kansas Child Health Plan. We look forward to working closely with your office in completing the review and approval of our Plan.

Sincerely,

Rochelle Chronister  
Secretary

enc:

cc: Joe Tilghman, Regional Administrator  
Janet Schalansky, Deputy Secretary  
James Scott, Health Insurance Specialist

RC:BLGH:bpl

## KANSAS CHIP QUESTIONS

**1. Civil Rights Assurances - Please provide an assurance that the Title XXI State Plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance.**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (P. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 50), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (P. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Educational Amendments of 1972 (P. L. 92-318), as amended, and all requirements imposed by or

pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (P. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

**Implementation Date - We understand from your verbal discussions with HCFA Regional Office staff that your implementation date for HealthWave (Title XXI) is January 1,1999. However, your SCHIP has the proposed effective date as July 1,1998. Please clarify.**

The State CHIP effective date of July 1, 1998 refers to the date at which Administrative Processes and Procedures will be in place. January 1 represents the date when healthcare services begin.

**Section 2. General Background and Description of State Approach to Child Health Coverage.**

2.3 What is the status of the Caring Program? If there are plans for its dissolution, please provide an outline for transitioning these children to HealthWave (Title XXI). If the Caring Program is not dissolved, how will it be coordinated with HealthWave (Title XXI)?

The Caring Program has chosen, at their own volition, to redirect their focus from child services to health care needs of other Kansas groups. On October 1, 1998 the Caring program will no longer be accepting applications. The Caring program will be assisting with transitioning the present recipients to HealthWave.

Is the Caring Program considered "health insurance coverage" as defined in HIPAA? If it is considered "health insurance coverage" how will the State address this in their crowd-out strategy?

The Caring Program is a charitable organization that provided donated services to the uninsured children of Kansas. The charities will be redirected to other focuses. In that the Caring Program had no true business function (i.e. no profit objectives) there is no concern of crowd out.

**Section 6. Coverage Requirements for Children's Health Insurance.**

6.1 Please provide a copy of the benchmark (state employee standard HMO) coverage and describe any differences between the SCHIP benefit package and the benchmark.

The benchmark plan is attached. The differences between the CHIP benefit package and the benchmark is that the CHIP benefit package provides for everything that is medically necessary for a child and is equivalent to the State of Kansas EPSDT benefit package.

**Section 6 Attachment A**

**Behavioral Health** - Please clarify if adjustment disorders, anxiety disorders, and post-traumatic stress disorders could be covered as a medically necessary service.

Yes.

**Vaccine Purchases** - The State plans to encourage MCO's to participate in the Vaccines for Children Program (VFC). However, children enrolled in CHIP are considered ineligible for VFC. What assurances can the State provide that children enrolled in CHIP will receive proper vaccination coverage?

The State of Kansas is deeming our CHIP children as state eligible children for immunizations. The Department of Social and Rehabilitation Services is entering into an agreement with the Kansas Department of Health and Environment to buy vaccines for children off of their federal contract. Providers in the CHIP program will have their vaccines provided to them off of this

contract.

## **Section 9. Strategic Objectives and Performance Goals for the Plan Administration**

### **9.9 What kinds of opportunities will the public have to continue to be involved, in addition to the implementation workgroups? Specifically, how have Native Americans been involved in the process thus far and what ongoing activities will be available in the future?**

The public has multiple opportunities to continue to be involved in the CHIP program. Some of these opportunities are:

- The Statewide Outreach Council - This group is an outgrowth of the partnership of the organizations and individuals that provided input to the CHIP program in the State of Kansas. Specifically these people and organizations are the Governor of Kansas, Secretary of Social and Rehabilitation Services, Kansas Department of Health and Environment, Commission of Mental Health and Developmental Disabilities, Commission on Adult and Medical Services, Kansas Children's Service League, United Methodist Health Ministry Fund, Kansas Association for the Medically Underserved, Kansas Action for Children, Kansas Hospital Association, Kansas Ecumenical Ministries, Children's Mercy Hospital, United Methodist Western Kansas Mexican-American Ministries Care Centers and Clinic, and Mercy Hospital.
- MAXIMUS, the Clearinghouse contractor, is committed to forming consumer focus groups.
- The KAN Be Healthy Advisory group meets on a quarterly basis.
- The Local Health Departments meet on a quarterly basis.

Native American involvement is facilitated through semi-annual meetings with the Secretary of the Department of Social and Rehabilitation Services and tribal leaders. In addition, the Department of Social and Rehabilitation Services also has a staff person who is the Native American Liaison. In October of 1998, a retreat will be held for policy staff of SRS and tribal social service organizations. The CHIP program will be a topic of discussion.



**9.10 What is the source of state funds?**

State General fund dollars that were appropriated by the Kansas Legislature are the source of state funds.

**OVERVIEW OF THE BENEFITS SCHEDULE**

**1999 Managed Care Benefits Schedule**

**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.

**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 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

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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.

### **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 Aided 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.

## **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.

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 (Immunizations will be covered through a replacement program - see RFP Section 10.4b for information on the Immunization Program)
- 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 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.

## 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.

## 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.

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