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

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

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

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

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

The estimated baseline number of uninsured children in Kansas is 60,000 as was reported to HCFA in the 1998 Annual Report.

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

This number is based on 3-year average Current Population Survey (CPS) March Supplement data used to establish the original financial allocations to states. This number is based on the three year average for 1993, 1994 and 1995.

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

The State believes this estimate is not statistically reliable due to the small sampling size on which the CPS is based. The questionable reliability of CPS data for small population states like Kansas is widely recognized as a data limitation in evaluating SCHIP programs. The numerical range for the estimate is plus or minus 12,000 uninsured children. An example of the volatility of this number is the change in subsequent three year averages. For 1994, 1995, 1996 the average was 52,000 +/- 12,000; for 1995,1996, 1997 the average was 53,000 +/- 12,000; and for 1996, 1997, 1998 the average was 42,000 +/- 11,000. All of these changes occurred before the implementation of the S-SCHIP program.

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

children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

The State has made significant progress in providing comprehensive health insurance benefits to thousands of previously uninsured Kansas children. As of September 30, 1999 there were 12,909 children enrolled in the separate SCHIP program, HealthWave. In addition, approximately 12,267 children had been added to the Medicaid program as a result of the HealthWave outreach/application process. In the first nine months of HealthWave operation over 25,000 of the estimated 60,000 uninsured children were covered by health insurance. It is important to remember the CPS estimate of uninsured children includes Medicaid and HealthWave eligible children as well as children of benefits eligible state employees who are excluded from coverage by Federal law. We have very little other consistent, reliable information to source to assess changes in the uninsured rates across the state. As noted in the comments to 1.1.2 the baseline number of uninsured children in the State is not particularly reliable. The lack of a consistent baseline makes the evaluation of the effectiveness of the S-SCHIP program much more difficult in terms of reducing the total number of uninsured children.

As an update, for March 2000 there are 16,040 children enrolled in HealthWave and an additional 17,800 children in Medicaid as a result of the HealthWave application process. The State is pleased with the level of enrollment we have been able to achieve but are still very committed to finding all of the eligible uninsured children in the State and enrolling them in health insurance coverage.

An outside evaluation being conducted by the Kansas Health Institute, in cooperation with the Department of Social and Rehabilitation Services (SRS)("the Department") and other entities, over the next three years will give us additional information regarding this issue. One of the projects in the evaluation is to examine the impact of HealthWave on reducing the number of low-income uninsured children, explain the existence of low-income children who continue to be uninsured, and identify differences in health care access and health status between insured and uninsured low-income children. The Kansas Health Institute evaluation is discussed in more detail in Section 5 of this evaluation.

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

With regard to the number of children enrolled, the State utilizes eligibility system data to track enrollment. The State's automated eligibility system is used to determine eligibility for both the Title XXI and Title XIX programs. Children determined to be eligible for the Title XXI program are identified with a separate code and are readily distinguishable from any other eligibility group. The additional Title XIX eligible children identified through the HealthWave application process are a subset of a larger eligibility group in the automated system. To determine the number of additional Medicaid children the eligibility file must be cross-matched with HealthWave applications registered

on our clearinghouse contractor's information system. If a Medicaid eligibility file matches up with a HealthWave application, we have established that the child entered the Medicaid program through the HealthWave outreach/application process.

A complete list of data sources is not yet available for the outside evaluation but data could include CPS information and a new population based survey.

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

The Department is very comfortable with the accuracy of the number of children enrolled in the separate HealthWave program because children are uniquely identified on the statewide automated eligibility system and on a separate information system operated by our Clearinghouse contractor. The number of additional children determined to be eligible for Medicaid is somewhat less reliable because it must be determined through a matching of Medicaid eligibility files on one system with applications registered on another system. There is limited opportunity to validate the numbers of Medicaid children identified through the HealthWave process because they are a subset of all Medicaid eligible children and the automated eligibility system does not separately identify them by how they came into the program. There is more room for error in this process but we feel comfortable with the accuracy of the Medicaid numbers at this time. Due to the method of collection and system limitations, the reliability of this system of identification of new Medicaid eligible children will lessen over time. The State will continue to refine its ability to track increased Medicaid eligibility as a result of SCHIP outreach.

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

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

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

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

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach

additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Reduce the number of uninsured non-Medicaid eligible children under 19 years of age and below 200% FPL in the State of Kansas	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.	Data Sources: Administrative data and Current Population Survey (CPS) data. Methodology: Count number of children enrolled in HealthWave as of dates. Numerator: Denominator: Progress Summary: As of September 30, 1999 there were 12,909 children enrolled in HealthWave. The original estimate given in the state plan did not account for the number of Medicaid eligible but-not-enrolled children discovered as a result of the SCHIP joint application process. As of the same time period approximately 12,267 additional children were determined to be Medicaid eligible.
OBJECTIVES RELATED TO CHIP ENROLLMENT		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Assure that the enrolled children with significant health needs have access to appropriate care.	Reduce the number of cases of hospitalization due to asthma among the enrolled children.	Data Sources: Administrative data for hospital stay and services. Methodology: Numerator: Denominator: Progress Summary: The Department has not be able to analyze encounter claim data from our managed care organizations. Because HealthWave has no fee-for-service component, we are dependent on this encounter data for utilization information. We hope to be able to begin analyzing this data shortly.
Assure that the enrolled children receive high quality health care services.	By December 31, 2000, at least 90% of SCHIP enrollees will report overall satisfaction with their health care.	Data Sources: Consumer Assessment of Health Plans Study (CAHPS) survey results. Methodology: Numerator: Denominator: Progress Summary: CAHPS survey information is not available for the period ending September 30, 1999.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Increase the percentage of enrolled children with regular preventive care.	By December 31, 1999, at least 75% of enrolled children through 2 years of age will receive one or more age-appropriate immunizations.	Data Sources: Health Plan Employer Data and Information Set (HEDIS) data. Methodology: Numerator: Denominator: Progress Summary: As of September 30, 1999 HEDIS information is not available. HEDIS information covering calendar year 1999 is due to the State in June 2000.
Increase the percentage of enrolled children with regular preventive care.	By December 31, 1999, at least 80% of enrolled children will receive one or more Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.	Data Sources: HCFA-416 report (Note: This source should be referred to as an administrative report for EPSDT screens not HCFA-416 which is a Medicaid report) Methodology: Health plans will use claims data and beneficiary information to calculate the number of exams required compared to the number completed by age group. Numerator: EPSDT exams reported Denominator: Total exams needed per periodicity schedule Progress Summary: No information is available for the period ending September 30, 1999. See comments following chart for updated information.

OTHER OBJECTIVES		
Prevent a crowd-out of employer-based health insurance for employees with SCHIP-eligible children	Maintain the proportion of children under 200% FPL who are covered by employer-based health insurance.	Data Sources: Administrative data and CPS data Methodology: Numerator: Denominator: Progress Summary: As of September 30, 1999 the State has no information to evaluate this measure. During implementation of HealthWave a six-month uninsured waiting period was initiated to prevent crowd out. Reliable information regarding the number of people in employer-based insurance is not currently available.

Additional Narrative Information on Strategic Objectives

Objective #1: Reduce the number of uninsured non-Medicaid eligible children under 19 years of age and below 200% FPL in the State of Kansas'

As of December 31, 1999, there were 15,206 children in HealthWave and an additional 16,399 children in Medicaid as a result of the HealthWave application process for a total of 31,605 previously uninsured children with health insurance coverage. An accurate estimate of whether the total number of uninsured non-Medicaid eligible children below 200% FPL is decreasing and the reasons for such change is not available. One limitation is that CPS data cannot distinguish between Medicaid eligible and non-eligible. A second limitation is that no CPS data covering the HealthWave coverage period is available, nor will it be for several years. Data showing the number of children enrolled in HealthWave is the only information we have at this time to measure the program's effectiveness in this area.

An outside, three-year evaluation being conducted by the Kansas Health Institute should give us some additional information in this area. One of the projects within the evaluation is to examine the impact of HealthWave on reducing the number of low-income uninsured children in Kansas, explain any continuing presence of uninsured low-income children, and identify differences in health care access and health status between insured and uninsured low-income children.

Objective #3: Assure that the enrolled children with significant health needs have access to appropriate care.

As noted in the table above, encounter data needed to evaluate this objective is not available at this time. There is an additional source of information the Department hopes to utilize in this area. An outside evaluation is underway conducted by the Kansas Health Institute which should give us additional

information regarding the experience of all children enrolled in HealthWave with regard to access to and appropriateness of care. This is designed to be a three year evaluation beginning in the first quarter of CY 2000 so information will not be available until at least late in CY 2000.

Objective #4: Assure that the enrolled children receive high quality health care services.

Coverage began on January 1, 1999 and the health plans were exempt from CAHPS requirements for the first year due to implementation issues and the lack of choice among health plans for beneficiaries (i.e. there is only one health plan available in each region). HEDIS data, which includes CAHPS information is required but is not yet available. HEDIS data is due from the managed care organizations in June 2000. Additional information will be gathered through the outside Kansas Health Institute evaluation discussed briefly in Objective 1 and 3. Additional information on the outside evaluation is available in Section 5 of this evaluation.

Objective #5: Increase the percentage of enrolled children with regular preventive care.

EPSDT screens for calendar year 1999 were 47.44% and 56.0% for the two HealthWave physical health managed care organizations. The State believes there are outstanding claims and reporting issues which need to be resolved before these percentages will be truly reflective of what is occurring in the HealthWave program.

SECTION 2. BACKGROUND

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

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

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

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion (M-SCHIP)

Name of program: _____

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

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

Name of program: HealthWave

Date enrollment began (i.e., when children first became eligible to receive services): January 1, 1999

___ Other - Family Coverage

Name of program: _____

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

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

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

___ Other - Wraparound Benefit Package

Name of program: _____

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

___ Other (specify) _____

Name of program: _____

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

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

NA

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

NA

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

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

In implementing HealthWave, one of the major goals was to make it as much like a private health insurance plan as possible while providing a comprehensive package of benefits. The design of HealthWave was impacted by a desire to distance it from the "welfare stigma" attached to Medicaid. Although we did not have good data on the number of Medicaid eligible but not enrolled children, we knew anecdotally there were children not being enrolled in Medicaid for a variety of reasons. The positive and negative aspects of the current Medicaid program were analyzed to determine what would make the new program more attractive to families. Examples of negatives considered were the complex application/eligibility determination process, the identification card, lack of outreach and education and poor written communication with families. The comprehensive Medicaid benefit package for children (Early and Periodic, Screening, Diagnosis and Treatment (EPSDT)) was viewed as a positive and the S-SCHIP package was designed as an EPSDT equivalent.

A limited benefits program administered by Blue Cross Blue Shield of Kansas, the Caring Program for Children, existed for 10 years prior to the implementation of HealthWave. The program was discontinued December 31, 1998, the day before HealthWave began covering children. This was done so that children previously enrolled in the Caring Program could participate in HealthWave and not be subject to the 6-month uninsured waiting period. This program served a similar population consisting largely of families with too much income to qualify for Medicaid but not enough to afford private coverage. However, the State would be able to provide a much more comprehensive benefit package to these children through the SCHIP program. SRS worked with Caring Program administrators to enroll as many of their children as possible in HealthWave.

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

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

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

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

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

_X_ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
_x_ Provision of continuous coverage (specify number of months _12)
_x_ Elimination of assets tests
_x_ Elimination of face-to-face eligibility interviews (mail-in application)
_x_ Easing of documentation requirements

Concurrent with the implementation of HealthWave on January 1, 1999, changes in Medicaid eligibility policies for poverty level children's programs were also implemented to align with the simplified HealthWave guidelines. The desire was to have the same basic eligibility determination guidelines for the two programs to facilitate the joint application process. The only additional information needed to determine Medicaid eligibility as opposed to SCHIP is the child's social security number (If the family requests prior medical coverage, additional medical bill information will be required.). After Medicaid eligibility is determined there will be referral to child support enforcement as required by federal law. This has created some barriers to encouraging families to remain in the Medicaid program after they applied for HealthWave but is not something the State can change at this point.

Medicaid eligibility changes, as well as the substantial outreach done for SCHIP and the use of a joint application, have resulted in a substantial increase in the number of children determined eligible for the Medicaid program. The changes listed above have made the application process for Medicaid much simpler and more accessible. Throughout the operation of the S-SCHIP program, the ratio of SCHIP eligible children and children determined to be Medicaid eligible as a result of the joint application has remained either equal or with more Medicaid eligible children than SCHIP eligible. As noted in other sections of this evaluation, the number of additional Medicaid children is determined through a data match process between our Clearinghouse contractor's system and the statewide automated eligibility system.

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

Because the HealthWave program has only been operational since January 1, 1999 the Department has limited data on welfare reform trends since implementation. However, the number of people receiving TAF (Temporary Assistance for Families) assistance has continued to decrease over the last several years and has not reversed course at this point although the rate of decline has slowed. As a result of this continual decline, the number of children receiving Medicaid coverage through such participation has decreased. The State has made provision for the continuation of coverage through the Transitional Medical program but not all families continue to participate or reapply after the transition period is over. These children may account for a number of the Medicaid eligible-but-not-enrolled children that have been "discovered" through the HealthWave joint application process. We do not have data to confirm this theory but it may account for the large numbers of Medicaid eligible children that have been enrolled since HealthWave began.

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

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

Information from the Kansas Insurance Department (KID) indicates that all of the above changes have taken place during the last year. However, there is no information available indicating the extent to which these factors have affected the affordability of or accessibility to private coverage.

___ Changes in the delivery system

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

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

_X__ Changes in the demographic or socioeconomic context

- ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
- _x_ Changes in economic circumstances, such as unemployment rate (specify) The unemployment rate continues to remain near record lows for the State.

According to the Kansas Department of Human Resources, the January 1999 unemployment rate was 4.0 percent and was 3.1 percent in September 1999. The Department is unsure what effect this has on the level of uninsurance. On one hand, more people are employed but there is greater employment in the retail and service sectors which are less likely to provide health insurance benefits for families.

___ Other (specify)_____

___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	State-designed CHIP Program
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide (state divided in three regions for contracting purposes)
Age	Birth to 19
Income (define countable income)	Under 200% FPL but above Medicaid stair-step eligibility based on age and family income. (See addendum to Table 3.1.1 for definition and further information.)
Resources (including any standards relating to spend downs and disposition of resources)	No asset test required
Residency requirements	Children must live in the State.
Disability status	N/A

Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	Cannot currently be covered by health insurance or have dropped such insurance without good cause in the last six months.
Other standards (identify and describe)	N/A

Addendum to Table 3.1.1

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

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

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

Title XIX Child Poverty-related Groups	____Gross	_X__Net	____Both
Title XXI Medicaid SCHIP Expansion	____Gross	____Net	____Both
Title XXI State-Designed SCHIP Program	____Gross	_X__Net	____Both
Other SCHIP program_____	____Gross	____Net	____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups	150% of FPL for children	<1
	133% of FPL for children aged	1-5
	100% of FPL for children aged	6-19
Title XXI State-Designed SCHIP Program	200% of FPL for children aged	<1
	200% of FPL for children aged	1-5
	200% of FPL for children aged	6-19

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

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

Table 3.1.1.3		
Family Composition	Title XIX Child Poverty-related Groups	Title XXI State-designed SCHIP Program
Child, siblings, and legally responsible adults living in the household	Y	Y
All relatives living in the household	N	N
All individuals living in the household	N	N

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

Enter "C" for counted, "NC" for not counted and "NR" for not recorded.

Table 3.1.1.4		
Type of Income	Title XIX Child Poverty-related Groups	Title XXI State-designed SCHIP Program
Earnings Earnings of dependent children	NC	NC
Earnings of students	C-Adults NC-Children	C-Adults NC-Children
Earnings from job placement programs	C	C
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC	NC
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC
Education Related Income Income from college work-study programs	NC	NC
Assistance from programs administered by the Department of Education	NC	NC
Education loans and awards	NC	NC
Other Income Earned income tax credit (EITC)	NC	NC
Alimony payments received	C	C
Child support payments received	C-current support only	C-current support only
Roomer/boarder income	C	C
Income from individual development accounts	NR	NR
Gifts	C-if > $50.00	C-if > $50.00

Type of Income	Title XIX Child Poverty-related Groups	Title XXI State-designed SCHIP Program
In-kind income	NC	NC
Program Benefits Welfare cash benefits (TANF)	NC	NC
Supplemental Security Income (SSI) cash benefits	NC	NC
Social Security cash benefits	C	C
Housing subsidies	NC	NC
Foster care cash benefits	NC	NC
Adoption assistance cash benefits	NC	NC
Veterans benefits	C (except for Aid & Attend, UME & housebound)	C (except for Aid & Attend, UME & housebound)
Emergency or disaster relief benefits	NC	NC
Low income energy assistance payments	NC	NC
Native American tribal benefits	NC-first $2000/year	NC-first $2000/year
Other Types of Income (specify) Interest Income up to $50.00/month	NC	NC
Lump Sum Payments	NC	NC
Tax Refunds	NC	NC
Bona fide Loans	NC	NC
Reimbursements for out-of-pocket expenses	NC	NC
Workmen's Compensation and Unemployment Comp.	C	C

3.1.1.5 What types and amounts of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes __X__ No

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

Table 3.1.1.5		
Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI State-designed SCHIP Program
Earnings	$200 per wage earner	$200 per wage earner
Self-employment expenses	25% of gross or actual income-producing costs	25% of gross or actual income-producing costs
Alimony payments Received	$0	$0
Paid	$0 (no credit given)	$0 (no credit given)
Child support payments Received	$0	$0
Paid	$0 (no credit given)	$0 (no credit given)
Child care expenses	included in wage earner expense	included in wage earner expense
Medical care expenses	$0	$0
Gifts	$0	$0

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

Title XIX Poverty-related Groups __x__No ____Yes (complete column A in 3.1.1.7)

Title XXI State-Designed SCHIP program __x__No ____Yes (complete column C in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

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

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI State-designed SCHIP Program (C)
Countable or allowable level of asset/resource test	N/A for all	$
Treatment of vehicles: Are one or more vehicles disregarded? Yes or No		
What is the value of the disregard for vehicles?	$	$

When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? (Enter I or A)		

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes _x_ No

3.1.2 How often is eligibility redetermined?

Table 3.1.2	
Redetermination	State-designed CHIP Program
Monthly	
Every six months	
Every twelve months	X

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

_X_ Yes ° Which program(s)? Children eligible for CHIP (HealthWave), or Medicaid under the poverty level programs, section 1931 and extended medical program have continuous eligibility

For how long? 12 months continuous eligibility

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

___ Yes ° Which program(s)?

How many months look-back? _____

_X_ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ° Which program(s)?

Which populations? _____

Who determines? _____ _X_ No

Note: By state law, the Kansas SCHIP program is delivered through a capitated managed-care system statewide with no fee-for-service component. This delivery system is incompatible with presumptive eligibility. The state has implemented an expedited eligibility determination process to decrease the lag time between application and coverage.

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

_X_ Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify. No, the simplified, mail-in joint application is only used for medical benefits for children. However, eligibility for Medicaid and CHIP can also be determined from the standard application form used to determined eligibility for other benefits (e.g. food stamps, child care assistance, etc...) if the family also chooses to apply for those benefits.

___ No

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

The State has made significant progress in simplifying the eligibility determination process for both the S-SCHIP program and the poverty level Medicaid programs for children. We believe these changes have facilitated the enrollment of thousands of previously uninsured children in coverage through HealthWave and Medicaid. However, we also realize that no system is perfect, especially when implementing in a tight time frame with limited administrative funding, so we will continue to evaluate and improve the process.

The strengths of the eligibility determination process include:

The Application: A simplified joint application is used for both the Medicaid poverty level program and HealthWave. The application packet includes a colorful brochure, the application and a postage paid return envelope. (See attachment 3.1.7) The nine question application makes it easier for families to apply for health insurance coverage for their children as no other application forms are needed for a child to be determined eligible for either HealthWave or Medicaid. If a family is applying for other benefits (food stamps, cash assistance, child care or medical assistance under another category), HealthWave eligibility can be determined from the standard application form. This assures medical benefits are being offered to all families seeking program benefits from the agency.

Mail-In Application Process: There is no face-to-face interview requirement for any

medical assistance programs, allowing the application process to be handled entirely by phone and mail. Families applying only for HealthWave or poverty level medical assistance are able to mail applications into a centralized location with a postage-paid envelope. HealthWave applications are available by calling the toll-free hotline or by picking one up at a wide variety of locations throughout the state.

Centralized Eligibility Unit: The Department has contracted with a private vendor to operate a centralized HealthWave Clearinghouse where most of the day-to-day program administration occurs. One of the major functions of the Clearinghouse is eligibility determination. The mail-in applications are received, registered, processed, and maintained at the Clearinghouse. The exception is for applications containing family members already receiving benefits from the Department. When these applications are identified at registration they are immediately forwarded to one of the 105 county offices for processing so that all of a family's needs are handled in one location. State eligibility staff are co-located with contract staff at the Clearinghouse and both determine eligibility for HealthWave. If an application being processed appears to have Medicaid eligibility involved it is transferred to a state staff person for final eligibility determination. This centralization helps to facilitate the joint application process because potential Medicaid cases do not have to be sent to a separate location for final processing causing a delay.

Toll-Free Phone Number: The implementation of a toll-free helpline number was not only designed to aid in outreach and marketing but also the facilitation of centralized eligibility. With the toll-free number, any person submitting an application can call to request an application, get assistance in completing the application, check the status of an application already submitted, or ask for additional information. The toll-free phone line is operated from 7 a.m. to 7 p.m. Monday through Friday and from 8 a.m. to 5 p.m. on Saturday. Limited information about specific application status or questions is available after "normal" business hours and on Saturday due to the unavailability of the automated eligibility system. However, the contractor's internal information tracking system is operational and many questions can be answered using this system during non-traditional hours.

Automated Eligibility System: Eligibility for both the HealthWave and children's poverty level Medicaid programs are determined under the same program designation in the statewide automated eligibility system. This ensures an automatic determination of HealthWave or Medicaid eligibility based on applicant information entered into the system. Once determined to be eligible, the automated system transfers information on the children to the appropriate fiscal agent/enrollment broker (there are separate entities for HealthWave and Medicaid at this point in time). The system automates the required screen and enroll process and eliminates the need for additional procedures. Both state staff (Clearinghouse and field office) and contract eligibility staff utilize the same automated system which also ensures a consistency in determinations.

Eligibility Policies: Eligibility policies for Medicaid were simplified in concert with the

implementation of HealthWave. A standard $200 per wage earner earned income disregard has been implemented as well 12 months continuous eligibility for children. A family determination has replaced the separate determinations based on income/poverty level and income rules have been standardized. Verification requirements have been reduced and the asset test has been eliminated. Streamlined eligibility policies for HealthWave and Medicaid were designed to be as consistent as possible to facilitate the processing of joint applications.

As with any new system design there are weaknesses in the eligibility determination system. The agency continues to analyze our functions and develop improvements to the current processes. The weaknesses include:

Mail-in Application Process: Obtaining timely and complete information/verification has proved to be a challenge with the mail-in process. If an incomplete application is received information must be requested by phone and mail. This process can delay final eligibility determination.

Centralized/Field Processing Structure: Because the cases of families with other agency program involvement are maintained at local offices cases may transfer back and forth between the Clearinghouse and the field offices as family needs change. This may cause confusion for families who are notified of the transfers but may not understand the reason. This issue is especially true for HealthWave families who may not associate the program with the Department.

Program Designation: Confusion regarding the differences between HealthWave and Medicaid, especially in families with children covered under both programs, has occurred. Also, there has been some confusion/dissatisfaction among a small population of individuals intending to apply for HealthWave coverage but who were actually eligible for Medicaid coverage. As will be described in Section 5, the Department is working towards creating a more seamless single program (from the public perspective) to eliminate some of the confusion and make the actual funding source of coverage more invisible to the public and beneficiaries. In the intervening period, the Department is making efforts to improve communication regarding these issues with families.

Automated Eligibility System: Although system work continues to progress, the State's long-time automated eligibility system continues to struggle to meet the demands placed on it by new program/policy designs.

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

At the end of the reporting period for this evaluation (September 30, 1999) the State had not

reached a redetermination period due to the 12 month continuous eligibility provisions for HealthWave and Medicaid children. The following explains planned redetermination procedures as of the evaluation date and anticipates potential strengths and weaknesses. Actual experience after September 30th is discussed in bracketed text. In general, redetermination/renewal is designed to be even more simplified than the original determination process with less verification to help ensure children remain covered by health insurance.

The anticipated strengths of the redetermination process include:

Joint Renewal Application: Families will be mailed a single renewal application (planned to be the same as the original application) for all children in the family (including both Medicaid and HealthWave eligibles).

[Shortened Renewal Application: A single page redetermination application is being used in the Clearinghouse to try and increase the rate of completion. A copy is attached to this evaluation as attachment 3.1.8.]

Simplified Earnings Verification: The State will allow a single paycheck stub to suffice as earned income verification for review applications as opposed to the two months verification required in the original determination.

Contact With Families: The Department is planning to make additional contact with families beyond the sending of the renewal application to encourage them to complete the renewal process on a timely basis so children do not have a lapse in coverage. [Staff in the Clearinghouse have been pro-active in encouraging re-enrollment by sending out reminder postcards before sending the renewal form and making follow-up phone calls. Outreach staff have also been involved in calling families not returning renewal information to offer assistance and answer questions the family might have about the process. Staff in the local offices have also practiced some of these same activities. Where this has been done, it has been successful in increasing the rate of return.]

As with the original determination process, there are still issues to be worked out and improvements to be made regarding the renewal process. Anticipated weaknesses of the redetermination process include:

Communication Regarding Renewal Requirements: Because of the commercial model design families may be confused by the need to re-enroll and the process to do such. The State anticipates that the mail-in application process, for all of its other advantages, may not be conducive to communication of these important requirements to families. An additional issue concerns premium payment requirements. Families must be current with all required premium payments by the end of the continuous eligibility period for the child(ren) to be eligible for

renewal. Communication of these requirements is sent to families along with other premium information but without the face-to-face contact it is difficult to know whether the families understand the requirements and the consequences of not complying. [Actual experience, though limited, has shown confusion does exist with some families. Efforts are underway and will continue to be made to improve the communication with families. One effort at this is the sending of postcards by Clearinghouse workers to families before sending out the renewal application. Another is some additional premium payment information that has been developed to help remind families of the necessity to have their premiums current by the end of the 12 month eligibility period.]

Additional Processing Time: As has occurred with the original application process, the State anticipates that extra contact may be necessary to collect additional verification or information. A mail-in process does not provide a face-to-face forum to communicate requirements with the family and get information personally. The delay in sending and receiving information slows down processing time and in the case of renewal, may cause a lapse in coverage for the children. [The State has experienced some delays in processing renewals due to the need to collect additional information. Information requirements were reduced from the original application requirements in anticipation of this issue but the effectiveness of those efforts is not clear at this time. It is not known whether it is the level of information required from families at renewal or an unfamiliarity with the renewal process in general that causes delays and confusion.]

12 Month Continuous Eligibility: The implementation of 12 month continuous eligibility is a major program component and a significant improvement over previous policies. However, the State is unsure of the effect it will have on the renewal process. Changes during the year are not reacted to and may build up over time. We do not know the number of changes that will actually happen within this population but a large number of changes in families may overwhelm a simplified, mail-in renewal process. [Actual experience has shown that a number of families have had significant changes in their lives during the previous twelve months. These include changes in household composition, changes in income and changes in address that can affect the eligibility determination. A simplified review process is not designed to handle major changes and confusion and delays sometimes result. The State will continue to work on improving the process to accommodate this issue and no consideration is being given to changing the continuous eligibility provisions as a result of this issue.]

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

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are

covered, the extent of cost-sharing (if any), and benefit limits (if any).

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

Table 3.2.1 CHIP Program Type S-SCHIP

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	**T**	NA	Medical necessity
Emergency hospital services	**T**	NA	Medical necessity
Outpatient hospital services	**T**	NA	Medical necessity
Physician services	**T**	NA	None
Clinic services	**T**	NA	Medical necessity
Prescription drugs	**T**	NA	Medical necessity
Over-the-counter medications	**T**	NA	Medical necessity
Outpatient laboratory and radiology services	**T**	NA	Medical necessity
Prenatal care	**T**	NA	None
Family planning services	**T**	NA	None
Inpatient mental health services	**T**	NA	Medical necessity
Outpatient mental health services	**T**	NA	Medical necessity
Inpatient substance abuse treatment services	**T**	NA	Medical necessity
Residential substance abuse treatment services	**T**	NA	Medical necessity
Outpatient substance abuse treatment services	**T**	NA	Medical necessity

Table 3.2.1 CHIP Program Type S-SCHIP			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Durable medical equipment	**T**	NA	Medical necessity
Disposable medical supplies	**T**	NA	Medical necessity
Preventive dental services	**T**	NA	None
Restorative dental services	**T**	NA	Orthodontia is not a covered service
Hearing screening	**T**	NA	None
Hearing aids	**T**	NA	Medical necessity
Vision screening	**T**	NA	None
Corrective lenses (including eyeglasses)	**T**	NA	Medical necessity
Developmental assessment	**T**	NA	None
Immunizations	**T**	NA	None
Well-baby visits	**T**	NA	None
Well-child visits	**T**	NA	None
Physical therapy	**T**	NA	Medical necessity
Speech therapy	**T**	NA	Medical necessity
Occupational therapy	**T**	NA	Medical necessity
Physical rehabilitation services	**T**	NA	Medical necessity
Podiatric services	**T**	NA	Medical necessity
Chiropractic services	**T**	NA	Medical necessity
Medical transportation	**T**	NA	Medical necessity
Home health services	**T**	NA	Medical necessity

Table 3.2.1 CHIP Program Type S-SCHIP			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Nursing facility			
ICF/MR			
Hospice care	**T**	NA	Medical necessity
Private duty nursing	**T**	NA	Medical necessity
Personal care services	**T**	NA	Medical necessity
Habilitative services	**T**	NA	Medical necessity
Case management/Care coordination	**T**	NA	None
Non-emergency transportation	**T**	NA	None
Interpreter services	**T**	NA	Medical necessity

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

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

The goal in designing the HealthWave benefits package was to provide comprehensive services within a delivery system designed to mirror private health insurance coverage. With this in mind, the state decided to use a benchmark package (state employees benefits) and add the requirement of coverage of all medically necessary services. The result was essentially an Early Periodic Screening Diagnosis and Treatment (EPSDT) equivalent package (the package offered to children in Medicaid). Subsequent to the original State Plan approval, the coverage has been reclassified as Secretary-Approved coverage due to the addition of the medical necessity language to the benchmark package. The equivalency of the benefit package to EPSDT was

important to maintaining consistency of coverage for children who move between Title XIX and Title XXI due to the state's "stair-step" eligibility levels for Title XIX. This is also important for families who may have children in both programs due to age differences. The term "stair-step" eligibility refers to the variance in Medicaid eligibility levels by age and income (refer back to Section 3.1.1 for further clarification).

As indicated by the paragraph above, children in HealthWave receive a very comprehensive package of benefits including preventive services, office visits, dental care (excluding orthodontia), prescription drugs, hospital care, prenatal care and delivery (for pregnant HealthWave beneficiaries), vison and hearing, mental health and substance abuse services. There are almost no benefit limitations due to the medical necessity language added as a requirement for the health plans. An exception to this equivalency is the limitation on the coverage of orthodontia in the dental benefits portion of plan. The managed care organizations delivering services in HealthWave may impose prior authorization requirements or other rules regarding beneficiary participation but they must meet contract requirements regarding access to care, quality of care and medical necessity. A full range of preventive services including, but not limited to, screenings, physicals, dental cleanings, dental sealants and immunizations are covered by HealthWave. There are no co-payments or deductibles associated with any of the services provided. The only cost sharing imposed on families is a monthly premium for families above 150% of the poverty level. Through HealthWave, the State has been able to make a full range of preventive, primary and acute care health services available to thousands of Kansas children who were previously without health coverage.

Children with special health care needs are not separately enrolled in a specialized program. These children receive all of the medically necessary services they require through the standard HealthWave benefit package. The agency cooperates with the Kansas Department of Health and Environment (KDHE) Children with Special Health Care Needs (Title V) program to identify special needs children and coordinate their care to the extent possible. Any child requesting services from the Title V agency is given the simplified HealthWave application to complete. The Title V agency affixes a sticker to the application indicating that the child is a special needs child. The sticker also requests a medical spendown determination be done if the original determination indicates that the child is neither HealthWave or Medicaid eligible due to excess income. In this instance, the Title V program may pay the spendown for the family so that the child will receive Medicaid services. If the child is determined to be HealthWave eligible, the Title V program works with the managed care organization to which the child is assigned to coordinate services for the child. Specialty clinics associated with the Infant and Toddler services may enroll a network provider in order to deliver services through HealthWave and encourage care coordination. Staff at KDHE's Title V program have access to the state's automated eligibility system and can track the eligibility of any children they refer through the application process. Through coordination efforts and a comprehensive benefits package, children with special health care needs are able to receive the level of services they require.

Enabling services are a part of the comprehensive HealthWave benefits package. All medically necessary services are provided including non-emergency medical transportation, home visits, individual needs assessment and translation of written materials. MCOs participating in HealthWave have developed informational materials in both English and Spanish. The contracts with the MCOs do not specify all of the enabling services required to be offered. However, the MCOs are expected to comply with quality of care and access to care standards that are listed in the contract and must offer enabling services to meet these standards where necessary.

3.2.3 Delivery System

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

Table 3.2.3

Type of delivery system	State-designed CHIP Program
A. Comprehensive risk managed care organizations (MCOs)	Yes, we are required by state law to have statewide capitated managed care only in our S-SCHIP program.
Statewide?	_X_ Yes ___ No
Mandatory enrollment?	_X_ Yes ___ No
Number of MCOs	2 (Note: these MCOs are responsible for physical health and dental services. Dental services are provided as described below.)
B. Primary care case management (PCCM) program	No
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	One contractor for statewide, capitated, managed behavioral health services including mental health and substance abuse services. Two subcontractors for capitated, managed dental services. These MCOs contract with the two physical health MCOs and do not contract directly with the state.
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	No
E. Other (specify)	No

All HealthWave benefits are delivered through a capitated managed care system statewide as required by state law. There is no fee-for-service or retroactive coverage in HealthWave. All services are delivered through managed care organizations (MCOs) who contract with the State. (Note: Although the State pays MCOs a capitated monthly amount per child, the payments from the MCO to the provider may be made on a fee-for-service basis.) Delivery of services in this way furthers the State's goal of encouraging the use of primary and preventive care and reenforces the medical home concept. Case management and care coordination benefits are an integral part of this delivery system. The state has limited the risk exposure of the MCOs for certain services such as hemophiliac drugs, dental services over $1,500 annually, certain transplants and vaccines. For these services the state will pay on a fee for service basis except in the purchase of vaccines which are purchased through an agreement with KDHE, the state agency operating the Vaccines for Children (VFC) program. Because children enrolled in a S-SCHIP program are not VFC eligible, the state chose to declare them State Vaccine Eligible and make an agreement with the state's immunization program to purchase vaccines through the Federal contracts or the Minnesota Multistate. The HealthWave MCOs are responsible for administering the vaccines and enrolling their providers into the VFC program. These providers then track the amount and type of vaccines used for HealthWave enrolled children and SRS is billed by KDHE for the cost of these vaccines. As is evident by the description of the immunization process, the provision of immunization services was made much more complicated by the Federal VFC prohibition for separate state programs.

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/
co-payments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_X_ Yes, check all that apply in Table 3.3.1

Table 3.3.1	
Type of cost-sharing	State-designed CHIP Program
Premiums	X
Enrollment fee	NA
Deductibles	NA

Coinsurance/co-payments**	NA

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

Families with incomes between 151% and 175% FPL pay a monthly premium of $10. For families with incomes between 176% and 200% FPL the monthly premium is $15. These are family premiums and do not vary based on how many children in the family are covered. Upon enrollment, families are allowed to choose whether they wish to pay monthly, quarterly or annually. Families receive a monthly statement indicating the amount currently due, the amount previously paid and (if applicable) the past due amount. The statement comes with a detachable coupon on the bottom and a postage paid return envelope. (A sample statement is included as attachment 3.3.2). If they are behind on payments families receive additional notices encouraging them to become current and advising them of the consequences of not being current at the time of renewal. Children are not dis-enrolled for failure to pay premiums during the 12-month continuous eligibility period. However, all required premiums must be paid before a child will be allowed to re-enroll for the next eligibility period (assuming they are determined to be eligible at renewal). There is no lock-out period for re-enrollment as long as any past due premiums are paid.

The State of Kansas collects premiums through our centralized HealthWave Clearinghouse operated by a private contractor. All statements, notices, refunds, etc. are sent by the staff in the Registration and Premium Account Services Department. All premiums are collected by this department through a mail-in process. Payments are actually received at a bank lock-box and then electronically transferred to the private contractor's account. This eliminates the need for the contractor to handle funds at the Clearinghouse. Funds are then electronically transferred to the state on a weekly basis. Families are strongly discouraged from paying with cash although procedures have been established to process such payments.

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

_X_ Employer
_X_ Family
_X_ Absent parent
_X_ Private donations/sponsorship
___ Other (specify)

The State does not specifically restrict any person or group from paying the premium for a family. The only restriction is that no state or federal funds can be used to pay the premium unless otherwise authorized by the source of the funding.

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

NA

3.3.5 If deductibles are charged: What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

NA

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

All outreach materials advise potential applicants that premiums may be required based on their family income. Families are notified of their cost sharing responsibility when they are notified of their child's eligibility for HealthWave. Families who have cost-sharing are sent a letter explaining their obligation and giving them the opportunity to choose either a monthly, quarterly or annual payment option. The family will then receive statements with a detachable coupon and postage-paid return envelope. Because Kansas only has a minimal ($10 or $15 per family above 150% FPL) monthly premium and no other cost sharing, the 5 percent cap is not a factor for HealthWave families.

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
_X__ Other (specify) Because Kansas only has a minimal ($10 or $15 per family above 150% FPL) monthly premium and no other cost sharing, the 5 percent cap is not a factor for HealthWave families.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

NA

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

Families in HealthWave do not have co-pays or deductible so the State does not believe cost sharing is an issue with regard to utilization of services once children are enrolled in the program. One theory, which we cannot substantiate at this time, is that utilization by premium paying families may be higher because they are "paying for" the coverage as opposed to families with no cost sharing responsibility. The Department may be able to prove or disprove this theory when we begin the process of analyzing encounter data from the managed care organizations. Due to the non-fee-for-service delivery system, the state has no claims data to analyze regarding utilization and will be dependent upon the MCOs for this information.

The state has not done a study regarding the effect of premium on program participation and we only have anecdotal information at this point. Our limited anecdotal information seems to indicate widespread support by families for the cost sharing concept. There seems to be a general feeling that cost sharing lessens the association of HealthWave with "public programs" or "welfare" and helps families feel as if they are making a contribution to their children's coverage. To our knowledge we have had few complaints regarding the premium responsibility other than non-premium paying families complaining that they do not get to pay a premium.

3.4 How do you reach and inform potential enrollees?

Outreach and marketing for HealthWave is conducted through two primary avenues. The first is through a contract with a private company to conduct the State's outreach and marketing activities. The second is through the State's participation in the Robert Wood Johnson Foundation's Covering Kids Initiative. Both of these avenues are extremely important in meeting the goals of finding every uninsured child in the state and convincing the families to apply for coverage. Beyond these two main avenues, outreach happens through a multitude of other sources including public officials, legislators, professional associations, statewide advocacy organizations, community based organizations, statewide service agencies and other organizations. All of these sources help to spread the word about HealthWave in their own ways through presentations, events and publications. From the very beginning of SCHIP, the opportunity to implement a program like HealthWave has been seen as an effort by the State of Kansas to help insure its vulnerable children and teens. The level of commitment from all of theses sources is evidence of this fact.

The Robert Wood Johnson (RWJ) sponsored Kansas Covering Kids Initiative is administered by the Kansas Children's Service League in cooperation with the State of Kansas and SRS. This initiative began in the spring of 1999 after the RWJ grant awards were announced. The goal of the the RWJ initiative is to use a grass roots approach to outreach in each of three pilot sites and a statewide initiative. Kansas Covering Kids was developed to be a compliment to the State's outreach by focusing on areas in the pilot site communities where standard outreach approaches may

not be as effective. The three pilot sites are located in both urban and rural settings in the east, southeast and southwest portions of the state. The pilot sites utilize many of the same approaches as does the statewide contractor but applies them in a more targeted, grassroots manner. Additionally, the pilot sites have been very innovative in discovering new ways to locate children and reach them with the HealthWave message. The RWJ statewide initiative also uses many of the same approaches and tries to find new ways of spreading the word about HealthWave. It is very important for the RWJ initiative and the State's outreach and marketing contractor to work together and avoid duplication and mixed messages.

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

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

Table 3.4.1

Approach	State-Designed CHIP Program*	
	T = Yes	Rating (1-5)
Billboards	**T**	3
Brochures/flyers	**T**	5
Direct mail by State/enrollment broker/administrative contractor	**T**	4
Education sessions	**T**	5
Home visits by State/enrollment broker/administrative contractor		5
Hotline	**T**	5
Incentives for education/outreach staff		
Incentives for enrollees		
Incentives for insurance agents		
Non-traditional hours for application intake	**T**	5

Table 3.4.1		
Prime-time TV advertisements	**T**	5
Public access cable TV	**T**	3
Public transportation ads	**T**	2
Radio/newspaper/TV advertisement and PSAs	**T**	4
Signs/posters	**T**	3
State/broker initiated phone calls		
Other Marketing item including pens, flying discs, magic springs, magnets, pins (staff wears), etc.	**T**	5
Other Radio and TV interviews including some with call-in sessions	**T**	5
Other Law enforcement (e.g. community policing, DARE, etc.)	**T**	5
Other Court service officers	**T**	5
Other Staffing of outreach workers who are from and live in the areas of the state they are assigned	**T**	5
Other School-based approaches beyond schools as a location/setting	**T**	5
Other Community contacts/liasons	**T**	5
Other Application assistance	**T**	5

* The responses in these tables reflects the efforts of the State funded outreach and marketing and does not necessarily reflect the efforts of the Robert Wood Johnson sponsored Kansas Covering Kids Initiative. However, the RWJ Initiative utilizes many of the same approaches as well as some additional methods.

> HealthWave has been successful in reaching our target audience by weaving marketing and outreach activities together. Marketing introduces families to the HealthWave concept and keeps awareness of HealthWave high throughout Kansas. This is very important because the population of uninsured children changes daily with people going into and out of the workforce. Also, many families needed to hear about HealthWave several times before they realize that this program may be for them and are willing to act on it. Action is the hallmark of outreach efforts. With the support of marketing initiatives,

outreach can bring the personal touch and insure that applications reach families and are filled out. Intermingling these efforts adds to the strength of marketing and outreach in realizing our goal of finding uninsured children and teens and getting them enrolled.

Marketing efforts reach massive numbers of people via billboards, radio, television, posters and flyers. Radio and television approaches utilized include on air interviews, news stories, public service announcements and paid commercials. Some of them were more effective than others. The areas which demonstrated the highest response rate were radio and television interviews, and paid radio spots. Calls to the toll-free hotline increased following an interview or the week during and after we ran commercials ran on radio.

Target marketing worked very well in getting applications. A direct mail campaign by SRS and the Kansas Department of Revenue to families who fell at or below the income guidelines generated a positive response in the number of calls and applications.

The State has also been successful in getting the cooperation of major retail stores and restaurant chains. For example, a major corporate sponsor will soon post HealthWave signs on their doors for customers to know they endorse HealthWave and suggest people call if they have uninsured children and teens.

The toll-free hotline is open from 7 a.m. to 7 p.m. Monday through Friday, and from 8 a.m. to 5 p.m. Saturday. These lines are staffed by enrollment and eligibility counselors. When people call, greetings are given in both English and Spanish. We average around 5,000 calls every month from interested families or families needing help with their applications. The extended hours of operation help people who cannot utilize a phone during the traditional working hours get information about HealthWave.

Less effective marketing tools were billboards, public access television, ads on buses both inside and outside and posters. These helped maintain the public's interest and awareness of HealthWave and were needed as part of the total package, but we saw little direct link between these avenues and phone calls or applications.

Marketing helps support outreach opportunities. For instance, colorful pens bring attention to the HealthWave booth at health fairs so people come over and outreach staff can then tell them about HealthWave. Magic springs and flying discs were outstanding in drawing all ages to our booth at the State Fair. Once at the booth, our outreach people are usually successful in getting the commitment of completing an application if the family needs one or giving the enrollment packet to someone they know who does not have health insurance. We found lots of grandparents who were raising uninsured grandchildren. Other grandparents were interested for their children or who had friends with uninsured grandchildren.

Outreach builds very effectively on a strong marketing foundation. Working together, they have

reached every area of Kansas from the rural areas of Western Kansas to the dense population centers around Kansas City and Wichita. Obviously, many Kansans learned about HealthWave from mass marketing efforts. However, they acted on this new program when someone they trusted reached them one-on-one.

Outreach workers were hired locally. Regional staffing gave assurance to people who would have viewed a new government program skeptically the trust factor which was so important in the early stages. Outreach workers are available at application assistance events to help families complete their applications. Many times it was not their ability to fill out a nine question application which was lacking, rather, families just needed the friendly encouragement from someone that this was a good thing for their children.

Outreach efforts are divided into four areas including presentations, community contacts, informational meetings and application assistance. Each area is important and a balance of each proved very successful in reaching the community. Outreach staff cannot just go into a community one time and leave with applications. That is why outreach workers have been to communities numerous times, working with various groups and organizations doing different things.

Schools have been a major focus for outreach and marketing beyond utilizing them as a location to find children. The outreach contractor has adopted schools, joined reading programs and made personal phone calls to school administrators to find out how they can become involved with school activities and reach children effectively. Involvement with the schools was an outstanding method of locating families with uninsured children. Schools are generally viewed as a safe place and their credibility is high. When the schools allowed us access to their students, we reached an incredible number of families.

Educational sessions training community based organizations helped extend the reach of the outreach coordinator. Additionally, staff at locations such as battered women's shelters and homeless shelters are trained to talk to their clients about HealthWave as they are likely to be someone their clients trust.

Community contacts are vital in spreading the word to business owners who helped reach their employees and told their fellow townspeople about this exciting new program. Outreach staff focused on small businesses in particular and they responded positively and encouraged customers to apply.

The one-on-one method of finding potential enrollees even includes buttons that each staff member wears which says simply "Ask me about HealthWave." Staff have been approached in banks, stores, restaurants, grocery stores and almost anyplace they go. These chance encounters almost always lead to applications.

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

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

Table 3.4.2		
Setting	**State-Designed CHIP Program**	
	T = Yes	**Rating (1-5)**
Battered women shelters (trained shelter staff)	**T**	3
Community sponsored events	**T**	4
Beneficiary's home (not random door-to-door but specifically referred or invited)	**T**	5
Day care centers	**T**	4
Faith communities	**T**	5
Fast food restaurants	**T**	5 (for getting employees to apply for their children) 3 for general public
Grocery stores	**T**	5 (for getting employees to apply for their children) 3 for general public
Homeless shelters (train staff)	**T**	5
Job training centers	**T**	5
Laundromats	**T**	5
Libraries	**T**	2 (5 if combined with another event)
Local/community health centers	**T**	5

Table 3.4.2		
Point of service/provider locations	**T**	5
Public meetings/health fairs	**T**	4
Public housing (includes Section 8 housing)	**T**	5
Refugee resettlement programs		
Schools/adult education sites	**T**	5
Senior centers	**T**	4
Social service agency	**T**	5
Workplace	**T**	5
Other (specify) Other businesses including beauty shops, restaurants and retail stores (chain & local)	**T**	5
Other (specify) County and state fairs	**T**	5
Other Correctional institutions (especially female facilities)	**T**	4
Other WIC Clinics	**T**	5
Other Farmers cooperatives	**T**	5
Other Community swimming pools	**T**	5
Other Indian reservations (e.g. Powwows, etc.)	**T**	5

* The responses in these tables reflects the efforts of the State funded outreach and marketing and does not necessarily reflect the efforts of the Robert Wood Johnson sponsored Kansas Covering Kids Initiative. However, the RWJ Initiative utilizes many of these same location s in addition to other locations.

The plan from day one was that outreach and education would take place wherever a willing listener could be found. The goal is to find every location where families might be and to try to work those places into the outreach process. The following information gives additional information on the locations where outreach has taken place.

Schools have been a major focus of outreach simply because schools are an integral part of children's lives. An incredible array of methods has been used to reach families through Kansas schools. Some of them include kindergarten round-ups, parent teacher conferences, presentations at staff meetings and Site Councils, or informational booths at school carnivals.

Outreach efforts are very similar to building blocks. Community contacts form a base of support for the program. Some of these lead to presentations. Presentations often lead to other presentations to different audiences or application assistance events.

Health fairs or other community celebrations are yet another opportunity to become involved in the community. For instance, application assistance events at a community of faith often began with a community contact to a pastor. Often the pastor would invite the outreach coordinator to do a presentation to their Ministerial Alliance. From that presentation, one or two ministers would indicate they had a lot of families who needed health insurance. This would lead to being present at the service, perhaps doing a short presentation and then holding an application assistance event after the service. Once again, we reached families through organizations in which they trusted, participated and believed -- "If my minister thinks this is a good thing, I'll get involved."

Employers have opened their workplace for informational meetings with their employees and hosted application assistance events. The outreach contractor has joined the Chamber of Commerce in several communities and received the endorsement of the Independent Business Association who helped us reach their members. Small business owners appeared to be much more responsive once the program received support from local business newspapers or organizations. Major retail chains have also been a great location for outreach. Walmart has been a very good supporter of HealthWave. Not only have outreach staff done educational presentations to their staff followed by application assistance, they did informational booths and application assistance at Walmart's across Kansas.

Health care providers were a natural link for outreach efforts. These included health departments, clinics and hospitals. Again, it was a process of building these relationships from the state level through the local sites. Working all areas at once helped solidify support.

Social services agencies continue to work with outreach staff in reaching their clients and lending support for the efforts in their community. Senior centers and adult education sites have been excellent areas to reach people. Presentations are done at most of the welfare to work training classes and they are followed up with application assistance during their breaks. English as a Second Language classes and GED classes have also proven useful in helping us reach families.

Public Housing, Section 8 Housing and Head Start locations helped us reach families. Again, we began with presentations to the staff, followed up by presentations to families and application assistance events. Since the staff believe in the program, they encouraged their clients to come to the program and supported our efforts.

Outreach also takes place in potential enrollees homes. Outreach coordinators have been to families homes to help complete applications. Outreach staff also continue to do door to door awareness campaigns in targeted locations.

Some additional locations of successful outreach were:

- WIC Clinics;
- Indian reservations (These became available to us through community contacts and the Indian Health Services' endorsement.);
- Community swimming pools;
- Farmers' Cooperatives (These are an important community link in rural areas.);
- Prisons and halfway houses (These have proven very successful. The outreach is much appreciated by parents who feel that they are unable provide for their children's well being.);
- County fairs and the State Fair; and
- Community celebrations.

All of these locations are very effective at building awareness and reaching people who have no idea that a government program could help them.

Once children are enrolled in HealthWave, information regarding the use of benefits is sent to the families by the appropriate health plan. Also, included with the notification of eligibility is a "HealthWave Helpful Hints" fact sheet which explains a bit more about the way the program works and what will happen next. A copy of the fact sheet is included with this evaluation as attachment 3.4.2.

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

At this time, Kansas has no truly accurate way of measuring the success of outreach. We do have several "unscientific" ways of measuring the success including the number of applications received, the number of children enrolled and the geographic distribution of children. An opportunity exists through the Robert Wood Johnson sponsored Kansas Covering Kids initiative to better evaluate outreach effectiveness through participant surveys and focus groups. These methods and opportunities are described in the paragraphs that follow.

A baseline on which to judge the overall number of applications received does not exist at this point in time. Additionally, we have no way to directly tie the receipt of an application to a specific outreach event/effort with a couple of exceptions where applications were identified. Due to these limitations, outreach staff attempt to measure the effect of more large scale events by the volume of phone calls and applications that arrive in the month following a major campaign push.

A second unofficial measure of outreach effectiveness is the geographic distribution of beneficiaries. Kansas has 105 counties and 82,000 square miles with a total population of about 2.5 million people. Some of these counties are in urban areas and many are in rural or frontier areas of the state with very low population density. The Department was very please when only three months into the program each of the 105 counties had at least one child enrolled in HealthWave. This has remained true throughout the program's operation. This distribution told the Department that we had succeeded in reaching families in all areas of a very diverse state and we continue to build on that success rate.

Outreach effectiveness can also be measured by the number of children enrolled in the program as compared with a baseline estimate. The only information we have to establish a baseline is CPS data broken down by county which estimates the number of uninsured children and the number of potential eligibles. The statewide number is the same as the overall baseline number of uninsured used for the financial allocations, 60,000 +/- 12,000 children. As has been mention before, the reliability of these estimates is questionable but there are options for other data are limited. Outreach staff refer back to this county data to measure how successful they have been in getting children enrolled in their area. As the enrollment for counties reaches 70 to 90 percent of their projected eligibles, less time in that county and efforts are concentrated in counties with a smaller percentage of penetration.

The State has an opportunity to gain additional information about the effectiveness of outreach efforts through the RWJ Kansas Covering Kids Initiative in cooperation with the Kansas Health Institute. A part of the RWJ grant was designed to conduct beneficiary surveys and focus groups to help determine which methods and locations of outreach are more effective in getting families to apply for health coverage for their children and teens. The Kansas initiative, administered by the Kansas Children's Service League and SRS, made a decision to combine their efforts with an evaluation being done by the Kansas Health Institute. The Kansas Health Institute evaluation is discussed more thoroughly in Sections 4 and 5 of this evaluation but in general, the three-year evaluation will be looking at a broad range of issues regarding the effectiveness of the HealthWave program. The evaluation will utilize a number of research methods including administrative data analysis, beneficiary surveys and focus groups. In order to avoid duplicative surveys and focus groups, possibly leading to poorer participation, the two projects decided to work together to get answers to their questions. Current plans are to include questions regarding the effectiveness of outreach in the surveys and focus groups conducted by the Kansas Health Institute. The evaluation is scheduled to begin in the first quarter of calendar year 2000.

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

HealthWave honors the variety of cultural and ethnic backgrounds of families throughout Kansas. This diverse population includes African Americans, Southeast Asians and Native American Tribes. Marketing and Outreach plans also focus on the Hispanic Ethnic culture.

The African American communities of faith have been a tremendous asset in helping outreach find families. They offered their facilities for events, application assistance and helped staff in door-to-door campaigns in the community. The outreach contractor also began a partnership with The United Nation of Islam. The HealthWave float in the Black Arts Festival parade won first place. Outreach staff also participated in the Martin Luther King Parade and celebrations. As a member of the Urban League, we participate in their Job Fairs, training events and public gathering attracting people and organizations working with diverse populations.

Ads in newspapers targeting the African American Community have been purchase and HealthWave billboards have been put up in largely African American neighborhoods. Several newspapers targeting this community have printed lengthy articles complete with photos. African American radio stations are included in our commercial buys and HealthWave has been featured in on air interviews.

The Spanish speaking population is reached in a variety of ways. First, the application materials and specialized event flyers are printed in Spanish. Bilingual outreach coordinators do presentations and radio interviews in Spanish in areas with large Spanish speaking populations.

Many outreach efforts have focused on the Spanish speaking community. Radio commercials in Spanish were purchased and placed in highly concentrated Spanish speaking sections of Kansas. Ads and feature articles in the Kansas Hispanic News and other papers targeting the Spanish speaking population were used. Ongoing presentations are done to English as a Second Language classes, Welfare to Work training classes and GED classes. Many of these presentations are followed up by an application assistance to help students complete their applications.

Ethnic celebrations are also opportunities for outreach efforts. Families attending Cinco de Mayo, Fiesta Mexicana and Mexican Fiesta September 16th Celebrations learn about HealthWave in both Spanish and English. The Spanish speaking places of worship have also opened their congregations to us. Not only have we done

presentations during their worship services, we've also held applications assistance right after their services.

HealthWave works closely with the Migrant Farm Worker program; the Service Education Retraining programs throughout Kansas for the Spanish speaking population and Hispanic Opportunity Potential Exploration Services. To reach the entire community, we've held application assistance events in fields during the summer farm work, garage sales and restaurants frequented by Hispanics. The State is now developing strategies to do outreach with the Kansas refugee populations. In one Hispanic Video store, we put flyers in the bags of every movie rented or purchased.

As a measure of our success, outreach staff were asked to participate in both the Hispanic Legislative Days and the Human Rights Commission Conference.

The Indian Nations have taken a special interest in getting tribal children enrolled. HealthWave was invited to participate in tribal health fairs and Pow-wows. The Prairie Band Potawatomie's Human Resources Director even invited HealthWave to do a presentation to their employees. There are four Indian casinos in Kansas and we work with all of them in a variety of ways including doing HealthWave presentations as part of their employee orientation for new hires.

The Indian Alcohol Treatment Services Director arranged for a HealthWave presentation to his staff and clients. A direct mail campaign was done for Native American families informing them that HealthWave is free to them. Finally, staff also participate in the Early Education programs for Indian children.

Outreach and Marketing will continue to develop relationships with the diverse populations represented in Kansas and extend our efforts to new populations. We have just reached an agreement and are developing plans to work with the Kansas Refugee Assistance Program. This will help us target the Bosnian, Smolain, Hmong, Russian Jews and Sudanese populations who have just moved into Kansas or are in the process of developing resettlement plans.

HealthWave understands that we must reach all uninsured families regardless of their language or ethnicity. The best way to do this is to understand and honor their cultural and ethnic heritage. HealthWave representatives serve on the Multi-Culture Task Force and are members of the planning committee for the Celebration of Cultures Festival highlighting ethnic diversity in Kansas.

3.4.5 Have any of the outreach activities been more successful in reaching certain

populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

The State currently has no quantifiable information at this time to measure the success of outreach activities on reaching specific populations. As discussed previously, the ability to measure outreach in general is very limited. Outreach staff have developed some sensitivity for what works and does not work in certain areas of the state through personal experience and general observation. Information on some of these was presented in Sections 3.4.3 and 3.4.4. Some additional examples of these observations are: Ethnic populations appear to respond more positively to personal contact with someone, especially with someone of their own ethnicity; small rural communities also respond more positively to someone who is from their own area and can understand their needs; and radio may work better than television in the frontier areas due to the amount of time people tend to spend traveling in cars and more limited television access. Additional information on this issue may be available through the planned study/evaluation of outreach effectiveness discussed in 3.4.3.

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

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

Table 3.5

Type of coordination	Medicaid* +	Maternal and Child Health (MCH)	Other: Public Health	Other: WIC	Other: Community Mental Health Centers
Administration	**U**				
Outreach	**U**	**U**	**U**	**U**	**U**
Eligibility determination	**U**	**U**			
Service delivery	**U**	**U**	**U**		**U**

Procurement	**U** (same staff)				
Contracting	**U** (same staff and coordinated contract periods)				
Data collection	**U**		**U**		
Quality assurance	**U** (same staff)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.
+ Items with notations in this column are not further described. All other functions are described more fully below.

Administration: Both the Medicaid and HealthWave programs are ultimately administered through the same division within SRS so the administration is inherently linked in many ways. The Department's Health Care Policy and Economic and Employment Services (eligibility) staff work with both programs simultaneously. There are separate fiscal agents for the two programs but they are tied together by a common SRS administration. For example, beneficiary phone calls to either fiscal agent's toll-free phone line are electronically transferred to the appropriate location if the wrong number was called. Additionally, administrative coordination exists within the HealthWave Clearinghouse due to the use of a joint application, centralized processing and the co-location of SRS eligibility staff.

Outreach: Outreach for HealthWave is coordinated with a variety of health care programs. The different programs, Medicaid, MCH (including Children with Special Health Care Needs (CSHCN)), Public Health and Community Mental Health Centers (CMHCs), all reach different populations so coordination is necessary to find all of the potentially eligible children and teens. Outreach coordination with Medicaid is accomplished through the use of a simplified, joint application and centralized application processing. Although outreach takes place under the umbrella of HealthWave, families are informed that their application will be screened for Medicaid eligibility and are encouraged to apply for health insurance coverage for their children regardless of the ultimate source the coverage. The MCH, Public Health and WIC programs are operated by the Kansas Department of Health and Environment (KDHE). HealthWave applications are distributed through local health departments, CSHCN offices, WIC clinics, MCH specialty clinics, and other entities under the direction of KDHE. Applications are also distributed through the CMHC system spread across the state.

Eligibility Determination: As described previously, HealthWave utilizes a joint Medicaid/SCHIP application that is processed by the same staff. Additionally, the state's automated eligibility system determines eligibility for both programs simultaneously. Information is entered into the system by eligibility staff and the system determines which program the child should be enrolled in based on the

child's age and family income. No separate screen-and-enroll or referral process is required due to these factors.

Eligibility determination is coordinated with MCH CSHCN program in a different way. Any child that requests services from the Title V agency is given the simplified HealthWave mail-in application to complete. The Title V agency affixes a sticker to the application indicating that the child on the application is a special needs child and requests a medical spendown determination if the original determination indicates that the child is neither HealthWave or Medicaid eligible due to excess income. In this instance, the Title V program may pay the spendown for the family so that the child will receive Medicaid services. Staff at KDHE's Title V program have access to the state's automated eligibility system and can track the eligibility of any children they refer through the application process.

Service Delivery: Service delivery is coordinated with MCH CSHCN beginning with the eligibility determination process described above. If the child is determined to be HealthWave eligible, the Title V program works with the managed care organization to which the child is assigned to coordinate services for the child. Title V specialists may enroll a network provider in order to deliver services through HealthWave and encourage care coordination. HealthWave MCOs are strongly encouraged to contract with local health departments, and other public health entities. The CMHC system is integrally involved in HealthWave service delivery as the MCO for statewide behavioral health services is a consortium whose members are the CMHCs. Service delivery is coordinated with Medicaid to the extent that many providers are both HealthWave and Medicaid providers. This allows for some consistency for families who may children in both programs or who switch between programs due to eligibility changes at renewal. Additionally, the HealthWave MCO covering two-thirds of the state is also the sole MCO for the Medicaid capitated managed care program with a large overlap of providers.

Data Collection: Data collection is coordinated with Medicaid to the extent that the same eligibility system is used for both programs. A variety of administrative data is collected from this system to measure performance of the programs. In addition, the same staff are generally responsible for the data collection for both programs and collection methods may be similar for both programs. HealthWave has worked with public health programs at KDHE regarding a variety of health status indicators. KDHE staff were involved in the development of a Health Status Survey designed to help gain information about children enrolled and measure the effectiveness of HealthWave. (This survey is discussed in more detail in Sections 4 and 5 of this evaluation.) Additionally, plans are underway to coordinate with public health in linking HealthWave and vital records for evaluation purposes.

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

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are

differences across programs, please describe for each program separately. Check all that apply and describe.

X Eligibility determination process:

_X Waiting period without health insurance (specify) 6 months with some limited exceptions such as employer dropping coverage, losing employment that provided coverage, non-custodial parent dropping coverage or inaccessibility of coverage.

_X Information on current or previous health insurance gathered on application (specify) Application question asks whether the child(ren) are covered by health insurance or whether coverage has been discontinued within the last six months and if so, why was the coverage discontinued.

___ Information verified with employer (specify)
___ Records match (specify)
___ Other (specify)
___ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

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

___ Other (specify)
___ Other (specify)

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

We have no definitive data on the extent of crowd-out. We do have some limited information on how many applications are denied due to the existence of insurance. However, this information may not give an accurate representation of the issue because of the information potential applicants are given regarding the requirement of children being uninsured for six months. Families who already have children covered by other insurance may not ever submit an application because they believe the child(ren) will not be eligible. We have no way at this time to discover the number of children whose parents drop other

insurance and let their child remain uninsured for six months before applying. If the insurance ended at least six months before application, no information is collected about that insurance coverage and why it was discontinued. The limited denial data we have seems to indicate that families with children already covered by health insurance are not submitting HealthWave applications.

We have systems data for our Medical Program (MP) that gives us limited information regarding the number of applications denied because of existing insurance. MP cases include both SCHIP eligible and poverty level eligible Medicaid children. The simplified HealthWave application can be used to determine eligibility for either program. However, denial for existing health insurance would only apply to SCHIP eligibility determinations. The denial data is not restricted to the simplified HealthWave application and could include denials for children who applied through the eight page application used to apply for other assistance programs as well as medical coverage. Another limitation of this data is that the denial reason is an eligibility worker input field subject to error. Finally, the automated eligibility system only allows one reason code to be entered and there could be more that one reason for denial (e.g. health insurance and excess income). It is up to the worker to choose which denial code to put it so there may some inconsistencies in the data. For the three month period July through September 1999 statewide MP denials due to existing health insurance averaged 4.0% of all denials. When narrowed down to applications processed in the Clearinghouse, which eliminates all but the simplified joint application, the average denial rate due to health insurances rises to 5.2% of all application denials. In this same period, the average number of monthly denials statewide was approximately 1,000 with and average of 399 denials at the Clearinghouse. The rates for the period of November 1999 through January 2000 were 5.2% statewide and 6.5% for the Clearinghouse. According to this data, the presence of pre-existing health insurance coverage accounts for a small percentage of denials.

SECTION 4. PROGRAM ASSESSMENT

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

4.1 Who enrolled in your CHIP program?

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

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your

HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

We have limited additional information at this time regarding the characteristics of children enrolled in HealthWave. We do not have much information to discuss the average length of enrollment and how that varies by characteristics. The HealthWave program began in January 1999 so we do not have access to a full year of data regarding length of enrollment as of September 30, 1999. The information given in table 4.1.1 is limited in its usefulness at this point because it may not give an accurate picture of what the program will look like after a longer period of operation. Also, the short time period of program operation has also allowed a very limited time to analyze enrollment trends. Finally, information systems for HealthWave are still being refined to give us the information we need to properly evaluate the program.

The limited information we do have regarding the HealthWave population during the first year was gathered through a Child Health Survey conducted by the agency from the beginning of the program. SRS has contracted with the University of Kansas Health Services Research Group (KU HSRG) to analyze the survey results. The survey was developed in cooperation with the Health Care Data Governing Board, which consists of representatives from the Kansas Health Institute, the Kansas Department of Health and Environment, the KU HSRG, the Kansas Foundation for Medical Care and others. An initial baseline survey was sent to all new HealthWave enrollees in the first five months of program operation. The survey was designed to gather some basic data regarding demographics, health status, school sick days, unmet health care needs, use of health services and environmental tobacco smoke exposure during the six months prior to enrollment in HealthWave when the children were uninsured. The response rate to the baseline survey was approximately 53 percent which was remarkable.

Information gathered from this survey has been published in the Children's Health Newsletter. Copies of this newsletter are attached to this evaluation. (See attachment 4.1) A summary of the information indicates that the enrollee's are predominantly school-aged and live in families with incomes just above poverty. Most of the children live in urban areas reflecting the population patterns in the state although enrollment as compared to population appears to be higher in rural areas. The older children tended to be less healthy and have more unmet needs for care. Unmet need appeared to rise with age and minority race/ethnic origin and urban residence increased the risk. In general, urban children were more at risk than rural children and they were more likely to be in fair to poor health, lack a regular health care provider, receive care outside a physician's office and have higher levels of unmet need. In CY 2000 a second survey with virtually identical questions is

being sent to children who have been in HealthWave for 12 months. This will help answer some limited questions about how HealthWave is impacting the lives of enrolled children. Data from the second survey should be available in the second half of CY 2000.

We hope to gain more information through an evaluation being done in cooperation with the Kansas Health Institute which is now beginning. This evaluation is being funded through various grants including the Packard Foundation, U.S. Health Resources and Services Administration, Kansas Health Foundation, United Methodist Health Ministry Fund, U.S. Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality), and other potential funders. This evaluation will be looking at many aspects of the HealthWave program including how well it provides services to particularly vulnerable children. These children include urban African-Americans, Hispanic immigrants, children from poor, rural areas, and children with mental health needs.

Table 4.1.1 CHIP Program Type S-SCHIP

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Percentage of unduplicated enrollees per year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	0	14,443	-	5.9	-	89.9%
Age						
Under 1	0	186	-	4.9	-	84.4%
1-5	0	2,717	-	5.5	-	83.5%
6-12	0	7,265	-	6.1		91.1%
13-18	0	4,275	-	5.9		92.2%
Countable Income Level*						
<=150% FPL	0	10,126	-	6.0		90.3%
151-175% FPL	0	2,801	-	5.8		90.6%
>175% FPL	0	1,516	-	5.5		85.9%

Table 4.1.1 CHIP Program Type S-SCHIP						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Percentage of unduplicated enrollees per year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Age and Income						
Under 1						
<=150% FPL	0	51	-	3.0	-	76.5%
151-175% FPL	0	94	-	5.6	-	92.6%
>175% FPL	0	41	-	5.5	-	75.6%
1-5						
<=150% FPL	0	1,296	-	5.6	-	83.3%
151-175% FPL	0	943	-	5.3	-	83.7%
>175% FPL	0	478		5.3	-	83.7%
6-12						
<=150% FPL	0	5,563	-	6.1	-	90.9%
151-175% FPL	0	1,119	-	6.1	-	94.5%
>175% FPL	0	583	-	5.6	-	87.5%
13-18						
<=150% FPL	0	3,216	-	6.0	-	92.5%
151-175% FPL	0	645	-	5.9	-	93.8%
>175% FPL	0	414	-	5.6	-	87.4%

Table 4.1.1 CHIP Program Type S-SCHIP						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Percentage of unduplicated enrollees per year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Type of plan						
Fee-for-service	NA	NA	NA	NA	NA	NA
Managed care	0	14,443	-	5.9	-	89.9%
PCCM	NA	NA	NA	NA	NA	NA

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

NOTE: Kansas began reporting enrollment data for our S-SCHIP in Quarter 2, FFY 1999; therefore, **data for FFY 1999 are only partial year.**

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

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

At this point in time we do not have good information regarding health insurance coverage prior to SCHIP enrollment. The only information we have regarding previous health insurance is from the application form. The information collected only covers the time of application and the six months previous to application. If the child is currently covered by insurance or coverage has been terminated within the last six months, the application is denied unless there was good cause for termination of coverage or there is Medicaid eligibility. If the child is determined to be Medicaid eligible, health insurance coverage information is collected for referral to our Health Insurance Premium Payment System.

We may be able to gather some additional information regarding previous health insurance coverage from the evaluation of HealthWave being done by the Kansas Health Institute

(briefly discussed in narrative to 4.1.1 above). The evaluation will use several methods to gather data including an enrollee survey, focus groups and administrative data. Through this information gathering we hope to gain additional knowledge about the children enrolled in HealthWave including information about their previous experience with health insurance. This is a three-year evaluation done in several stages and at this time we expect to start getting information by the end of CY 2000. (For more information refer to Section 5.1.7)

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

We have no information about the effectiveness of other public and private programs in the State in increasing the availability of individual and family health insurance for children.

4.2 Who disenrolled from your CHIP program and why?

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

Information regarding the disenrollment of children from HealthWave is very limited. Data reported to HCFA for the quarter ended September 30,1999 indicates that the quarterly disenrollment rate averaged 7.7% in the first three quarters of program operation. At this point, it is not clear whether these percentages are representative of normal program operations. Medicaid disenrollment rates for children for the same period averaged 7.9%. It appears at this time that disenrollment for the two programs is running relatively equal at this point in time. An important factor in this trend is that the State implemented 12 months of continuous eligibility for both programs on January 1, 1999 so the similarity is not unexpected. An important piece of information that the Department is missing is information on Medicaid disenrollment rates for children previous to January 1, 1999 to compare the rates before the implementation of continuous eligibility. The State began actively tracking disenrollment rates for Medicaid children after the implementation of HealthWave and continuous eligibility. Therefore, comparable information for previous time periods is not available.

The Department had not designed expectations for HealthWave regarding disenrollments before implementation. However, it would appear the vast majority of children are remaining in the program and not disenrolling and re-enrolling. More research needs to be done into the reasons for the disenrollment that is occurring. Whether the current rates are acceptable largely depends on why the disenrollments are happening. The Department's goal is to reduce disenrollments due to eligibility systems issues, eligibility

policy or program dissatisfaction but realizes that there will be some natural level of disenrollment with any program. Additionally, some of the reasons for disenrollment may be positive such as the coverage by other health insurance (children would not have to be disenrolled for this reason due to continuous eligibility provisions but many families may do so voluntarily). The Department will continue to develop information on disenrollments in the future in order to continue to improve the HealthWave program.

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

The HealthWave program began operation on January 1, 1999. At the end of the time period for reporting (September 30, 1999) HealthWave had only been in operation for nine months. Because HealthWave has 12 months of continuous eligibility, no children in HealthWave had reached renewal time.

As of the time of submission of this evaluation we do have some initial information regarding renewals during December 1999. This data is not intended to reflect what overall program performance will be over time and is only a "snapshot" in time of non-renewal. This information comes from MP (poverty level Medicaid and HealthWave) cases that were reviewed (redetermined) in December 1999 for January 2000 benefits. For cases that were closed as a result of these reviews, eligibility ended effective December 31, 1999. The following are some facts regarding renewals:

- Statewide, 7,422 MP cases were up for review.
- Statewide, 8,299 Medicaid children and 2,847 HealthWave children were up for review in December 1999.
- Statewide, 2,400 Medicaid and 634 HealthWave children lost eligibility as a result of failing to return the renewal/redetermination form.
- Of the 892 children who were on HealthWave but lost coverage at review, the following are the main reasons:
  - 634 (71%) lost coverage for failure to return the review form.
  - 94 (11%) lost coverage for failure to provide information.
  - 81 (9.1%) lost coverage due to excess earned income.
  - 21 (2.4%) lost coverage due to obtaining private health insurance.
  - 15 (1.7%) lost coverage for failure to pay premiums.
  - 9 (1%) lost coverage because the family requested case closure.

The Department does not have good information on what happened to children after they left HealthWave. Renewal information in December 1999 (after the end of this evaluation reporting period) indicates that a majority of children lost coverage because of failure to complete the renewal process. Some information was collected during the renewal

process through phone contacts with families not returning renewal applications. Outreach and eligibility staff at the Clearinghouse attempted to contact families not returning renewal forms to try and determine why the renewal had not been completed (e.g. other insurance, etc.) and whether there was anything the staff could do to help the family complete the process. .

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

As was noted in 4.2.2, the HealthWave program had not reached a redetermination period prior to September 30, 1999 (the end of the reporting period for this evaluation) so we do not have information regarding discontinuation at renewal to report for this period. We also do not have reliable information for the reasons for case closures during the continuous eligibility period.

Table 4.2.3 *		
	S-SCHIP	
Reason for discontinuation of coverage	Number of disenrollees	Percent of total
Total		
Access to commercial insurance		
Eligible for Medicaid		
Income too high		
Aged out of program		
Moved/died		
Nonpayment of premium		
Incomplete documentation		
Did not reply/unable to contact		
Other (specify)		

* Note: Table information was not completed because HealthWave had not reached a renewal/redetermination period as of September 30, 1999 due to 12 month contiguous eligibility period.

The State does not have any other information regarding disenrollments not at renewal at this time.

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

Because the State does not have adequate information on all children who disenrolled, efforts to re-enroll children who are still eligible occur on a case by case basis. If an eligibility worker discovers a child who has been inadvertently disenrolled a process is in place to re-enroll the child through a manual process. At the renewal process, (after the evaluation reporting period) efforts are made to assist individual families who do not complete the renewal process. If eligibility has lapsed due to non-completion of the renewal process, efforts are made to re-enroll the children with little or no lapse in health insurance coverage.

4.3 How much did you spend on your CHIP program?

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

FFY 1998 $0

FFY 1999 $13,310,236

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

Table 4.3.1 CHIP Program Type S-SCHIP

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	$0	$13,310,236	$0	$9,583,370
Premiums for private health insurance (net of cost-sharing offsets)*	$0	$11,640,219	$0	$8,380,958

Table 4.3.1 CHIP Program Type S-SCHIP				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Fee-for-service expenditures (subtotal)	$0	$12,455	$0	$8,968
Inpatient hospital services	$0	$0	$0	$0
Inpatient mental health facility services	$0	$0	$0	$0
Nursing care services	$0	$0	$0	$0
Physician and surgical services	$0	$0	$0	$0
Outpatient hospital services	$0	$0	$0	$0
Outpatient mental health facility services	$0	$0	$0	$0
Prescribed drugs	$0	$0	$0	$0
Dental services	$0	$0	$0	$0
Vision services	$0	$0	$0	$0
Other practitioners' services	$0	$0	$0	$0
Clinic services	$0	$0	$0	$0
Therapy and rehabilitation services	$0	$0	$0	$0

Table 4.3.1 CHIP Program Type S-SCHIP				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Laboratory and radiological services	$0	$0	$0	$0
Durable and disposable medical equipment	$0	$0	$0	$0
Family planning	$0	$0	$0	$0
Abortions	$0	$0	$0	$0
Screening services	$0	$0	$0	$0
Home health	$0	$0	$0	$0
Home and community-based services	$0	$0	$0	$0
Hospice	$0	$0	$0	$0
Medical transportation	$0	$0	$0	$0
Case management	$0	$0	$0	$0
Other services	$0	$12,455	$0	$8,968

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

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

Activities funded under the 10 percent cap include limited agency central office staffing and payment of private contractor for administrative functions. Administrative functions performed by the private contractor include outreach, marketing, eligibility determination, health plan enrollment, distribution of capitation payments to health plans, premium collection, operation of the toll-free help line and administration of surveys.

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

Particularly because the State implemented a separate state-designed program, as opposed to a Medicaid expansion, the administrative cap posed many challenges in designing and implementing the program. The goal was to make HealthWave look like a commercial health insurance product and not like a government program. To help accomplish this goal a separate administrative structure was developed to take care of the day-to-day administration of the program. In Kansas, this was implemented as a centralized clearinghouse operated by a private contractor. Because of the timing of the legislation and the short time line for implementation, the contract for this clearinghouse had to be procured well before any program expenditures would begin. Before a program begins, it is difficult to predict what the program expenditures will be and negotiate an administrative and outreach contract based on that prediction. In this process, the agency made a concerted effort to let the program design take the lead and then matched up funding to what that design required as opposed to letting the money direct the design.

After program implementation, when we had a clearer idea of how the program was going to operate and a better estimate of potential program expenditures, the Department began to re-allocate expenditures. The joint application and outreach allowed the state to reallocate some expenditures to Medicaid and Section 1931 Delinking funding based on the proportion of Medicaid and SCHIP work performed. Allocation of costs continues to be a struggle in order to properly claim federal match and fund program administration activities.

Table 4.3.2

Type of expenditure	State-designed CHIP Program	
	FY 1998	FY 1999
Total computable share	$0	$782,523
Outreach	$0	$550,041
Administration	$0	$232,482
Other	$0	$0
Federal share		$487,673
Outreach	$0	$167,457

Administration	$0	$320,216
Other	$0	$0

Note: Expenditures shown are total administration costs for SCHIP related activities. The mix of Title XXI and Title XIX activities within the HealthWave Clearinghouse allowed the state to allocate administrative expenditures between Title XXI, Title XIX and Section 1931 Delinking funding based on the proportion of Medicaid and SCHIP work performed.

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

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

* Foundation grants are only used to support outreach and evaluation functions outside of the state plan and are not used to match federal dollars for program activities. The agency cooperates extensively with foundation sponsored research and utilizes information gathered through such research to evaluate the success of our S-SCHIP program.

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

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

As required by State law, the HealthWave program is a capitated managed care program statewide and has no fee-for-service or primary care case management component. All services are delivered through managed care organizations for physical health, dental and behavioral health (mental health and substance abuse).

Table 4.4.1	
Approaches to monitoring access	**State-designed CHIP Program**
Appointment audits	
PCP/enrollee ratios	
Time/distance standards	MCO
Urgent/routine care access standards	MCO
Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO
Complaint/grievance/ disenrollment reviews	MCO
Case file reviews	
Beneficiary surveys	MCO
Utilization analysis (emergency room use, preventive care use)	MCO

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

Table 4.4.2	
Type of utilization data	State-designed CHIP Program
Requiring submission of raw encounter data by health plans	_x__ Yes __ No
Requiring submission of aggregate HEDIS data by health plans	_x__ Yes __ No
Other (specify)	___ Yes ___ No

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

At the current point in time we do not have access to encounter data from our managed care organizations. We are in the process of working out final systems issues with our contractors so that we will be able to access and analyzed this data. Additionally, we do not yet have Health Plan Employer Data and Information Set (HEDIS) data from our health plans due to the early point in our program operation this evaluation falls. HealthWave began providing services on January 1, 1999 so HEDIS data is not yet available for the health plans.

An additional way we monitor access to care is through the complaints and grievances process as well as through the appeals process. HealthWave MCOs are required to log all complaints and grievances they receive. These logs are submitted to the state on a quarterly basis. The logs are analyzed to determine what types of complaints have been received and whether they have been resolved satisfactorily. The Complaints and Grievances manager works with the plans on an ongoing basis to ensure that all complaints and grievances are handled appropriately. Complaints received by our agency's central office staff are also tracked. At this point in time, there is no indication from the complaints and grievances process that there is a significant access to care issue with HealthWave enrollees. During the evaluation period (January 1 - September 30, 1999) we had no appeals filed regarding access to care. Since the end of the evaluation period we have had one appeal filed regarding access to dental services.

As indicated in the chart in 4.4.1, the contracts with HealthWave MCOs have standards for network capacity, time/distance standards and other access standards. Because this evaluation occurs so early in program operations, we do not yet have complete data on these performance standards. However, we do not have information that indicates there are significant problems in accessing care for HealthWave enrollees.

The biggest challenges regarding access to care in HealthWave is in the rural and frontier western portions of the state and in dental services statewide. Many Western Kansas areas are sparsely populated with a general shortage of providers for the population at large. This is amplified by a reluctance to participate in managed care by many of the providers in this area. In general, Kansas is not a highly penetrated managed care State for commercial or public health insurance. A second challenge to MCOs is dental access. Kansas has a shortage of dentists for the population as a whole. This is exacerbated by a maldistribution of providers in certain areas. All of these factors present a challenge to HealthWave MCOs in recruiting sufficient providers to maintain an adequate network for beneficiaries. Issues to keep in mind at this point regarding access is the very compressed time frame MCOs had to recruit networks before beginning services on January 1, 1999

(contracts signed in September and October 1998) and the early point in time this evaluation occurs in relation to program operation. Because there are not fee-for-service or PCCM components in HealthWave, all access to services is measured through the MCO networks. The MCOs in HealthWave are continually working to expand networks to assure access to care for HealthWave children.

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

As noted above, we are not able to access all encounter data submitted by HealthWave MCOs as of March 2000 but are in the final stages of resolving outstanding systems issues and complete data should be available later this fiscal year. From this data we will be able to evaluate HealthWave enrollees' access to care using standards in Table 4.4.1.

HealthWave MCOs are required to report on 10 selected HEDIS measures and other selected performance measures required by contract. The HEDIS measures selected cover both access to and quality of care for HealthWave enrollees. The selected measures most applicable to access to care are: Children's access to primary care practitioners; and availability of primary care (mental health/substance abuse, dental) providers. HEDIS information is due from MCOs in June 2000.

Another way access to care is being evaluated is through a three-year evaluation of HealthWave being performed by the Kansas Health Institute in cooperation with our agency. This evaluation is being funded through various grants including the Packard Foundation, U.S. Health Resources and Services Administration, Kansas Health Foundation, United Methodist Health Ministry Fund, U.S. Agency for Health Care Policy and Research, and other potential funders. One of the functions of the evaluation is to determine the impact of HealthWave on health care utilization for low-income children in the program. This data will also be compared to the experience of a group of Medicaid enrollees. (See Section 5.1.7 for more information)

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

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

Table 4.5.1	
Approaches to monitoring quality	**State-designed CHIP Program**
Focused studies (specify) See description of Kansas Health Institute study discussed in 4.6	MCO
Client satisfaction surveys	
Complaint/grievance/ disenrollment reviews	MCO
Sentinel event reviews	MCO
Plan site visits	MCO
Case file reviews	
Independent peer review	
HEDIS performance measurement	MCO
Other performance measurement: Other performance measures required for health plans include measures for screenings and health status indicators. These are discussed below.	MCO

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

As noted above, we are not able to access all encounter data submitted by HealthWave MCOs as of March 2000 but are in the final stages of resolving outstanding systems issues and complete data should be available later this fiscal year. From this data we will be able to evaluate the quality of care received by HealthWave enrollees. Required HEDIS data is not available for the reporting period due the short program operation time and the length of enrollment required to perform HEDIS reporting.

One method the Department currently has to monitor quality of care is through the complaints and grievances process as well as the appeals process. The complaints and grievances monitoring process is briefly described above in 4.4.3. At this point in time, there is no indication from the complaints and grievances process that there are significant quality of care issues with HealthWave enrollees. To date we have had only one appeal

for the HealthWave program which occurred after the end of this evaluation period.

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

HealthWave MCOs are required to report on 10 selected HEDIS measures and other selected performance measures required by contract. Reports on HEDIS data from health plans are due in June 2000. The HEDIS measures selected cover both access to and quality of care for HealthWave enrollees. The selected measures most applicable to quality of care are:

- Childhood immunization status
- Prenatal care in the first trimester
- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, fifth and sixth year of life and adolescent well-care visits
- Inpatient utilization - General hospital/acute care
- Mental health services utilization
- Chemical dependency services utilization

Other selected performance measures relating to quality of care are screenings and health status indicators. Specifically, the screening information required includes: Health screenings at member's entrance and at specific intervals according to the American Academy of Pediatrics' Periodicity Schedule; and dental, vision and hearing screenings. HealthWave MCOs have a goal that 80 percent of eligible children will be screened according to the required schedule. Health status indicators measured include: Incidence of vaccine-preventable diseases; incidence of very low birth weight live births; rate of hospitalization for asthma; rate of avoidable hospitalization or extended ER/outpatient stay due to acute illness; consumer satisfaction surveys and other measures the plans can provide. Information for these performance measures is not available at this time.

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

One study that has been underway since the implementation of the program is the HealthWave Child Health Survey. The overall goal of this survey is to gather some limited data on HealthWave children both before enrollment and after enrollment to determine the effect of the program on children. The Department felt strongly that it was important to begin collecting at least limited data on children from the beginning of the program. SRS has contracted with the University of Kansas Health Services Research Group (KU HSRG) to analyze the survey results. The survey was developed in cooperation with the Health Care Data Governing Board, which consists of representatives from the

Kansas Health Institute, the Kansas Department of Health and Environment, the KU HSRG, the Kansas Foundation for Medical Care and others. An initial baseline survey was sent to all new HealthWave enrollees in the first five months of program operation. The survey was designed to gather some basic data regarding demographics, health status, school sick days, unmet health care needs, use of health services and environmental tobacco smoke exposure during the six months prior to enrollment in HealthWave when the children were uninsured. The response rate to the baseline survey was approximately 53 percent which was remarkable. Two editions of the Children's Health News, a newsletter produced utilizing this data, have been distributed. A copy of the newsletter is included with this evaluation. (See attachment 4.1) In CY 2000 a second survey with virtually identical questions is being sent to children who have been in HealthWave for 12 months. This will help answer some limited questions about how HealthWave is impacting the lives of enrolled children. Data from the second survey should be available in the second half of CY 2000.

SECTION 5. REFLECTIONS

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

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

5.1.1 Eligibility Determination/Redetermination and Enrollment

In general, the Department is very pleased with the efforts made to streamline eligibility determination/redetermination and enrollment activities. Eligibility requirements for Medicaid were simplified along with the implementation of HealthWave to coordinate eligibility policy between programs. Twelve month continuous eligibility was also implemented for both programs in furtherance of the Department's goal to keep children covered by health insurance on a consistent basis.

The Department believes the implementation of the HealthWave Clearinghouse has been a very valuable asset to the success of the program thus far. A majority of the day-to-day activities of HealthWave occur at the Clearinghouse which is operated by a private contractor.

One of the major functions of the clearinghouse is eligibility determination and enrollment. The mail-in applications are received, registered, processed, and maintained at the

Clearinghouse. The exception is for applications containing family members already receiving benefits from the Department. When these applications are identified at registration they are immediately forwarded to one of the 105 county offices for processing. State eligibility staff are co-located with contract staff at the Clearinghouse and both determine eligibility for HealthWave. If an application being processed appears to have Medicaid eligibility involved it is transferred to a state staff person for final eligibility determination. This centralization helps to facilitate the joint application process because potential Medicaid cases do not have to be sent to a separate location for final processing causing a delay. As discussed in Section 3.1.7, the use of the statewide automated eligibility system at the Clearinghouse and in the field improves consistency and automates the Medicaid screen-and-enroll requirements so that no additional procedures are needed to complete the determination process.

Enrollment into HealthWave health plans also occurs at the Clearinghouse as an automated process after eligibility determination (Medicaid enrollment takes place at a separate fiscal agent). The automated eligibility system automatically transfers HealthWave and Medicaid eligible children to the appropriate enrollment system on a pre-determined schedule. No additional efforts are required by HealthWave families as there is currently no choice of health plans in the program. In the future, if multiple health plans are available to families, a selection process will need to be developed. Eligibility records for Medicaid children are sent to the Medicaid fiscal agent for fee-for-service establishment and to begin the managed care enrollment process. The files for all cases processed at or transferred to the Clearinghouse are maintained at the Clearinghouse. Families with no other program involvement who have questions or need to make changes (i.e. change of address) can simply call the toll-free number.

The use of a single, simplified, joint application has also been instrumental in attracting families to the program. The HealthWave application is much easier to fill-out that the larger integrated application and is much less intimidating in terms of the information required for completion. The application was also designed to be colorful and appear more like a commercial program to encourage families to pick them up. The availability of the application is a variety of locations around the state as well as through the toll-free line has also been very important to the success of the program.

Improvement efforts need to continue in some areas. These areas include: the refinement of eligibility policies as they relate to the interaction between HealthWave and Medicaid; the automated eligibility system; the success in renewal/redetermination completion by families; communication of all information in other languages if necessary and general improvements in the agency's ability to track information about children who enroll and disenroll.

5.1.2 Outreach

A vital component to our outreach success has been the diversity of methods used to reach Kansas families with children and teens. By using a wide variety of approaches and locations, the State has succeeded in reaching families in all of the 105 counties from urban to frontier and all areas in between. No place or approach is easily discarded and almost everything has been tried at least once. There is no way to tell how effective something will be until it is tried. The variety of methods of outreach used in Kansas was discussed in Section 3.4. Although the lists of activities are very extensive, there are certainly areas that have not been discovered or utilized to their fullest extent and the State is always in search of new ideas.

Another important piece of outreach in Kansas has been the location of outreach coordinators across the state. The state was divided into outreach regions and coordinators who live in those areas were hired to the extent possible. Outreach is centered at the HealthWave Clearinghouse in Topeka to help ensure that the overall outreach effort is coordinated and comprehensive. As discussed previously, the hiring of local outreach workers helps all areas, especially Western Kansas, feel they are a part of HealthWave and increases the level of trust.

A final important aspect of the outreach and marketing has been the level of involvement from people and organizations all across the state. Even before the creation of HealthWave, people across the state wanted to be involved in expanding insurance coverage to Kansas children and teens. Without this level of support it would have been much more difficult to get HealthWave off the ground so quickly and with so much success. Nine months into the program, over 25,000 previously uninsured children were covered by health insurance through HealthWave and Medicaid in a state with an estimated 60,000 uninsured children under 200% of poverty and a total population of 2.5 million people.

As successful as outreach has been thus far, there are improvements to be made. In the future, outreach and marketing will need to be refined and more targeted to find the harder to reach families and to convince more reluctant populations to apply for their children. The State needs to undertake a more structured approach to analyzing the effectiveness of different types of outreach and marketing. The lack of solid information about outreach effectiveness has been an area of frustration. Another area in which we continue to try and improve is in the coordination of outreach efforts between all of the various groups doing outreach including federal agencies, national organizations and Kansas entities. This is particularly true between the Robert Wood Johnson Kansas Covering Kids Initiative and the state funded outreach contractor because of the overlap in outreach approaches. It is important that we have a single message and do not create confusion in the community

about who the groups represent. We continue to work on this coordination by improving communication and defining responsibilities.

5.1.3 Benefit Structure

The provision of a comprehensive benefit package to children is something the State of Kansas can be very proud of in designing HealthWave. Children in the program receive a full range of preventive, primary and acute care services for physical health, dental and behavioral health (mental health and substance abuse). The package is essentially an EPSDT equivalent package covering all medically necessary services with very few exceptions and limitations.

The equivalency of the Medicaid and HealthWave benefit packages is also important for families with children in both programs or for children who change programs at renewal due to age or income changes. The equivalency will also be important as the state moves towards an integration of the two programs into a more seamless, unified umbrella program (discussed further in Section 5.2).

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

The collection of premiums is another function handled by a private contractor at the HealthWave Clearinghouse. This allows for centralization of all the collections which helps maintain continuity in procedures and increase accountability. Cost sharing amounts are $10 and $15 per month for families above 150% FPL. However, families can choose to pay monthly, quarterly or annually in individual amounts that meet their needs as long as their total cost sharing obligations is met by the end of the child(ren)'s continuous eligibility period. Families will always receive a monthly statement (attachment 3.3.2) showing their current and past due amounts based on their monthly premium responsibility.

No significant problems have been encountered with the premium collection process thus far. Premium responsibilities do not appear to be disliked by families having a premium responsibility. The more common complaint is from families who do not have a premium responsibility and want to be able to contribute towards their child(ren)'s coverage. According to some families, the premium requirement makes them feel less like they are receiving a "handout". The costs of administering cost-sharing can sometimes exceed the amount collected. However, the State did not implement cost sharing to offset costs. Instead, cost sharing was implemented to make it look more like a commercial model and help families transition into commercial coverage as their income increases.

5.1.5 Delivery System

The capitated managed care delivery system in HealthWave has been both a benefit and a challenge. The benefits of the delivery system include the ability to properly manage the care of children in the program and a better ability to manage/estimate program costs. The management of care aspect is very important to the State's overall goal to improve the health outcomes of vulnerable children and ensure they receive all necessary preventive and primary care services. Although we currently have no reliable data to prove or disprove this assumption, we also believe that the lack of retroactive coverage may encourage families to seek coverage before they need it and utilize the services more effectively. Whether this is true or not is one of the many questions we have to answer to judge the effectiveness of the program.

The challenges of the structure primarily relate to provider networks, coverage delays and program continuity. As mentioned earlier in this evaluation, Kansas is not particularly well penetrated by managed care in either the commercial or public health insurance arenas. Some areas present particular challenges for MCOs to maintain adequate provider networks due to geography, provider shortage or resistance to managed care participation. The MCOs continue recruiting efforts to ensure that all enrolled children can receive the care they need.

The unavailability of fee-for-service coverage causes a delay in coverage after eligibility determination. HealthWave benefits do not begin until the first of the month following enrollment in an MCO. Enrollment happens approximately a week before the end of the month. Children whose eligibility is determined after this date will not receive coverage until the first of the next month resulting in approximately one month delay in coverage. Newborns whose family has no other connection with HealthWave (or Medicaid) will not receive coverage until and application is submitted (after birth), eligibility is determined and enrollment occurs. This delay will not generally be for more than two months assuming the application is filled out completely and depending on the timing during the month but retroactive coverage for that time period is not available.

The other consequence of no fee-for-service coverage in HealthWave is program continuity with Medicaid for families with children in both programs or children who switch programs. Medicaid offers immediate and retroactive coverage and families with newly enrolled children may be confused as to why one child gets retroactive coverage and the other does not. These issues will be addressed as a part of the integration of the two programs into a single health insurance program in the next couple of years.

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

The primary issue regarding crowd-out is the 6 month waiting period instituted by the State. The Department has heard from a number people that a waiting period unfairly

discriminates against families who have made sacrifices in other parts of their lives to provide commercial health insurance for their children in favor of similar families who did not provide coverage. Families whose children are covered face the choice of continuing to pay for commercial insurance, a very expensive prospect in many cases, or dropping the coverage and letting the child(ren) remain uninsured for six months. Alternatives, other than the elimination of the waiting period, that have been offered include adding additional exceptions such as unaffordability and reducing the length of the waiting period. The issue of crowd-out is one about which the Department is very interested in gathering more information. It is still unclear at this point whether crowd-out is really an issue or whether it is merely a perception of federal and state officials that will not be substantiated.

The Department is pleased with the level of coordination we have achieved with some of the other programs in the state but areas remain were a better level of coordination is needed to reach our goals.

5.1.7 Evaluation and Monitoring (including data reporting)

External Evaluation

As has been mentioned earlier, a three-year evaluation of HealthWave being performed by the Kansas Health Institute is currently underway in cooperation with SRS and other entities. This evaluation is being funded through various grants including the Packard Foundation, U.S. Health Resources and Services Administration, Kansas Health Foundation, United Methodist Health Ministry Fund, U.S. Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality), and other potential funders. Other entities involved in the evaluation are: the Kansas Department of Health and Environment; the University of Kansas Schools of Social Welfare and Nursing; the University of Kansas Medical Center; Kansas State University; and the Kansas Foundation for Medical Care. Various parts of this study have been discussed throughout this evaluation in response to various specific questions. In general this evaluation is designed to:

- Examine the impact of HealthWave on reducing the number of low-income uninsured children in Kansas, explain any continuing presence of uninsured low-income children, and identify differences in health care access and health status between insured and uninsured low-income children;
- Determine the impact of HealthWave on health status, quality of care, and utilization for low-income children in the program, and as compared to a group of Medicaid enrollees;
- Evaluate how well the HealthWave program provides health services to particularly vulnerable children including urban African-Americans, Hispanic immigrants, children

in poor, rural areas and children with mental health needs.; and

- Assess the effect of HealthWave on the health care market, particularly the traditional safety net providers that exist in rural and other disadvantaged areas of the state.

Data for the evaluation will be gathered through surveys, focus groups, agency administrative data and other secondary data such as vital statistics, hospital discharge data and the Kansas Health Insurance Information System. As mentioned in Section 3.4 regarding outreach, questions will be included in surveys and focus groups designed to evaluate the effectiveness of various forms of outreach. The questions are included as a result of cooperation between the Robert Wood Johnson Kansas Covering Kids Initiative and the Kansas Health Institute. The results of the evaluation will be shared with our agency as well as to other policy makers, legislators, state officials, advocacy groups and the general public over the next three years. The Department is very pleased and excited to be involved with this evaluation of HealthWave. Many of the questions being asked in this evaluation are very important to our own evaluation and the continual improvement of the program. Department resources for such extensive evaluation are limited, especially in light of the ten percent administrative cap for SCHIP. Thus, this outside evaluation is viewed as an invaluable opportunity to gain knowledge regarding the impact of HealthWave on Kansas children.

Internal Evaluation

The Department is very pleased that we were able to conduct the HealthWave Health Status Survey to gain some initial and continuing information about the children enrolling in HealthWave. (See section 4.6 for more information). Other internal evaluation has been limited due to constraints in time and funding. The HealthWave program has not been operational for long enough to get sufficient information from health plans to evaluate the delivery of services in a comprehensive manner through the use of encounter data, HEDIS information and performance measures. Additionally, resources to conduct any significant research through surveys and focus groups has been very limited largely due to the ten percent administrative cap. Comprehensive research consumes a substantial amount of staff time and financial resources not available with limited administrative dollars. Additional time and program experience should bring us additional information and opportunity to evaluate the HealthWave program internally.

5.1.8 Other (specify)

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

The State of Kansas is committed to a continual monitoring of the HealthWave and Medicaid programs to improve their ability to provide health insurance coverage for eligible children. Two

avenues being considered are the creation of a system to purchase employer-sponsored coverage for eligible families employed by small business and the integration of the Title XIX and Title XXI programs into a single health insurance program.

The State has been researching the integration of Title XIX and Title XXI since the creation of HealthWave as a separate SCHIP. The goal of the integration is to create a single public health insurance program for eligible children under a single program identifier such as HealthWave. Some of the guiding principles are to make the program family friendly and easily accessible while providing eligible children with quality, comprehensive health insurance coverage. Within this construct, children will still be served through the appropriate funding source but the distinction will be much more invisible to families. The plan is for managed care organizations and providers to be the same for both programs as well as benefit packages. There are a multitude of challenges both in the current system and program rules to creating a seamless system but the State continues to research ways to overcome these challenges.

During the 2000 Legislative session currently underway, the Kansas Legislature is considering legislation that would create a Business Health Partnership designed to facilitate the purchase of health insurance coverage by small businesses. Research regarding the participation of the Department's Title XXI and Title XIX programs in purchasing employer-sponsored coverage through this partnership is currently being done. The Department already operates a system to purchase employer-sponsored coverage through Medicaid but does not currently operate a similar program for HealthWave.

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

There are a number of areas where the Title XXI program can be improved. Some of these suggestion would take Congressional action. Many of these areas relate to the Notice of Proposed Rulemaking for SCHIP issued by HCFA in the fall of 1999. Comments on the proposed rules were submitted to HCFA in January 2000. Some of these suggestions may change depending on the outcome of the final rules. The following is a brief list of suggestions for program improvement:

- Reduce the bias against S-SCHIP plans by either imposing similar rules on M-SCHIP plans or reducing restrictions on S-SCHIP plans. One of the driving forces behind the creation of SCHIP as a block grant program was to give states flexibility to implement innovative programs within a set amount of dollars. The introduction of prescriptive rules, such as those in the Notice of Proposed Rulemaking (NPRM), limit the freedom of States to implement programs that suit the needs of our population. Two additional restrictions imposed on S-SCHIPs as opposed to M-SCHIP plans are: the prohibition on the participation of S-SCHIP children in the Vaccines for Children program and the ability of M-SCHIPs to claim SCHIP administrative dollars under the Title XIX administrative match when they reach the 10 percent administrative cap. The

restrictive rules and additional restrictions on S-SCHIPs can increase the cost of administration and program complexity.

- Eliminate the restriction on the coverage of the children of state employees who would otherwise be eligible. The Department has received a substantial number of comments from the public regarding the perceived unfairness of this rule. The State is aware of the federal cost-shifting concerns regarding this provision but would request that the discussion be reopened to further explore the policy issues.
- Re-examine the restrictions placed on the purchase of employer-sponsored coverage through Title XXI. Preliminary HCFA guidance and rules in the NPRM for such usage are more restrictive than for those in the Title XIX Health Insurance Premium Purchasing program. This seems contrary to what should happen with a block-granted, non-entitlement program. The current rules make the implementation of a purchasing program extremely difficult and administratively cumbersome for states. The purchase of employer-sponsored coverage is a very viable way of providing health insurance coverage for children whose parents work but cannot afford the dependent coverage their employer offers. A larger number of children could be covered for the same cost because employer-sponsored dependent coverage may cover more than one child in a family for the same cost. The State requests that HCFA reconsider the proposed rules regarding employer-sponsored coverage when creating final regulations.
- Reconsider the basing of the ten percent administrative cap on program expenditures to allow for the expenses involved in starting up a new S-SCHIP before program expenditures begin. Perhaps the ten percent could be based on the block grant the state is allocated. As is particularly evident in S-SCHIPs, it takes a great deal of up-front planning and expense to establish an new program and conduct outreach before the provision of any benefits coverage to children can begin. Without the up-front costs, there will be no children enrolled in coverage. The current design forces states to take a risk by tying up other funding sources to finance the up front costs and scramble to continually reallocate costs.

In general, the State Children's Health Insurance Program has been a successful cooperation between the state and federal governments as a way to help insurance millions of additional children nationwide. As with any new programs there will be complications and challenges to creating a program that fits the needs of all states. The State of Kansas is extremely supportive of the efforts made thus far and is willing to work with our Federal partners to continue to improve the program for the sake of all of the uninsured children in our state.