STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM
(KCHIP)

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM (KCHIP)

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
Neville Wise, Acting Commissioner
Department for Medicaid Services

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

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Lisa Lee, Division Director of KCHIP,
Department for Medicaid Services, 275 East Main Street: 6W-D Frankfort, KY 40632,
Phone: 502-564-4321, Fax: 502-564-0509

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

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☒ A combination of both of the above.

Kentucky has been working since November 1996 to increase health care access by all age groups. At that time a workgroup was convened by the Cabinet for Health Services and included many interested parties. Three target groups were identified: 1) Uninsured children; 2) Uninsured adults; and 3) Elderly with difficulty affording needed medicines. As Title XXI funds became available, the children's program became a priority. Several subgroups were formed to tackle specific issues such as the benefits package, financing, and policy issues including outreach, coordination, and evaluation.

Kentucky's Title XXI State Plan will expand children's access to health coverage by implementing state enabling legislation and building on the experience and infrastructure of the Kentucky Medicaid program. The Kentucky Children's Health Insurance Program (KCHIP) will adopt two approaches to expanding health care coverage for children; a Medicaid expansion and a state designed health insurance program.

KCHIP Medicaid Expansion

The current Medicaid program will be expanded to cover poverty level children 14 to 19 to 100% FPL, July 1, 1998. An additional CHIP Medicaid expansion will take place on July 1, l999, to cover targeted low income children from one to 19 in families up to 150% FPL.

KCHIP Separate Insurance Program

This Medicaid look alike is designed to cover children from birth to 19 years of age who are not eligible for Medicaid or the KCHIP Medicaid Expansion and have family incomes at or below 200% FPL. This program will become effective on November 1, 1999. Health care services will include all current Medicaid services with the exception of non-emergency transportation and EPSDT Special Services. Health care services will be provided through the existing Medicaid service delivery system.

Outreach

Many new outreach efforts will be implemented under the Title XXI program. The goals for outreach in the state will be to inform families of the program, assist them with enrolling their children, and follow through to get the children enrolled. Eligibility determination will continue to

be contracted by the Department for Medicaid Services to the Department for Community Based Services (DCBS). Local outreach will be coordinated by the Department for Public Health and will involve many community agencies and private non-profit organizations. Applicants may complete a mail-in application or go directly to the local offices to make an application. Local outreach is essential to explaining the process to potential applicants.

Implementation Timetable

The Medicaid expansion will be effective on July 1, 1998 or upon approval of this plan if approval is after July 1, 1998. The state is asking for approval of the Medicaid expansion component prior to the full Title XXI Plan approval, if necessary, so that Kentucky can begin covering a portion of the target population as quickly as possible. The CHIP Medicaid coverage of children from one to 19 in families up to 150% FPL will be effective on July 1, 1999. The state designed KCHIP program will be a Medicaid look alike for children from birth to 19 who are not eligible for Medicaid or the KCHIP Medicaid expansion with family income at or below 200% FPL and will become effective on November 1, 1999.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

We assure that in Kentucky expenditures for child health assistance will not be claimed prior to the time that the state has legislative authority to operate the State plan or plan amendment as approved by CMS.

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

We assure that Kentucky complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, **and part 91, and 28 CFR part 35.**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date:	**July 1, 1998**
Implementation date:	**July 1, 1998**

SPA #1 (Medicaid SCHIP Expansion to 150 FPL)

Effective date:	**July 1, 1999**
Implementation date:	**July 1, 1999**

SPA #2 (Separate Insurance Program)
Effective date: November 1, 1999
Implementation date: November 1, 1999

SPA #3 (Application and Recertification Process Change)
Effective date: June 1, 2001
Implementation date: June 1, 2001

SPA #4 (Application Process Change and compliance)
Effective date: July 1, 2002
Implementation date: July 1, 2002

SPA #5 (Cost Sharing)
Effective date: August 1, 2002
Implementation date: August 1, 2002

SPA #6 (Cost Sharing)
Effective date: June 1, 2003
Implementation date: June 1, 2003

SPA #7 (Cost Sharing)
Effective date: November 1, 2003
Implementation date: November 1, 2003

SPA #8 (Benefit, Cost Sharing, Delivery System)
Effective date: May 15, 2006
Implementation date: May 15, 2006

SPA #9 (Eligibility Determination)
Effective date: November 1, 2008
Implementation date: Withdrawn

SPA #10 (Eligibility Determination)
Effective date: November 1, 2008
Implementation date: November 1, 2008

SPA #11 (Premium Payments)
Effective date: July 1, 2010
Implementation date: July 1, 2010

SPA #12 (Children of State Employees)
Effective date: October 1, 2010
Implementation date: October 1, 2010

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination **(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))**

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

Population estimates for 1996 show that there are 3,883,723 people living in Kentucky. Of those 1,011,166 are children under the age of 19. Approximately 93,346 (9.23%) of Kentucky's children are African American.[1] The child poverty rate in Kentucky has steadily risen since 1979. It is estimated that in 1996 nearly three in ten Kentucky children lived in poverty. Another two in ten lived just above the poverty level.[2]

The Kentucky Legislative Research Commission (LRC) has studied the insurance status of the state for the past three years. Data for the first two reports were collected in two separate, random surveys of Kentucky households: The Kentucky Health Insurance Survey in 1996 and 1997 and the Current Population Survey for various years. For the Kentucky Health Insurance Survey, telephone interviews were conducted with 1,259 households. Based on these sources for 1997, LRC estimated that there were 154,000 uninsured children in the state, 123,000 of whom are under 200% FPL. Of those children, 45,000 (approximately 30%) are believed to be eligible for Medicaid under the current eligibility requirements. An additional 23,000 children ages 14 to 19 are between 33% and 100% FPL and would be eligible for the proposed Title XXI Medicaid expansion. Approximately 35,000 uninsured children would be eligible for the CHIP Medicaid expansion to children from one to 19 in families up to 150% FPL, and the remaining 20,000 children have family incomes between 150% and 200% FPL. This report did not study children by race or ethnicity.[3]

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

Any decrease that might be construed from these data cannot be attributed to KCHIP because the survey was conducted before KCHIP implementation. (Source: Michael Clark:

Status of the Health Insurance Market in Kentucky, 1998, Frankfort, KY: Legislative Research Commission, February, 2000.)

Medicaid is the only public health insurance program generally available in Kentucky. Medicaid currently covers children 0 to 1 at 185% FPL, from 1 through 5 up to 133% FPL, from 6 through 14 (effective SFY 2000) at 100% FPL, and 15 to 19 up to 33% FPL. Each year the State increases the age level of those covered at 100% FPL by one year.

In 1996, Medicaid served 348,045 children under 21 years of age, which is 29.3% of all Kentucky children under age 21 as of July 1, 1996.[4]

Category		Estimated # Uninsured
Age of Uninsured Children:		
	Age Under 1	5,560 (4%)
	Age 1-5	26,410 (19%)
	Age 6-15	77,840 (56%)
	Age 16 -18	30,580 (22%)

Source: LRC Research Memorandum No. 290. See endnotes.

Based on this data, the state has estimated that there will be 50,624 children eligible for the Medicaid expansion. Approximately 15,624 children would be eligible for the KCHIP insurance program.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

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

There are a variety of agencies and organizations currently involved in identifying children with health needs, many of whom are either Medicaid eligible or without creditable coverage. These organizations will be the first line of effort to identify potential KCHIP children. Kentucky will start with these organizations to identify potentially eligible children for KCHIP.

The Kentucky Department for Public Health is the largest single provider of direct patient care as well as support care for the uninsured and Medicaid enrolled children and adolescents. Direct services for this population include: preventive child health services (well child check-ups); prenatal services; Women, Infants and Children supplemental nutrition [WIC] services; preventive health education; immunizations; and family planning program services. Support services include nursing and nutrition counseling for pregnant

women, Resource Mothers program for pregnant and parenting teens, and the provision of information and referral via a toll-free telephone line. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family Planning program funds, federal WIC funds, Medicaid reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue. A variety of the above direct and support services are provided within each of the 53 District or County Health Departments, with health department service delivery sites in all 120 Kentucky counties. In State Fiscal Year 1996 over 175,500 children (birth through age 18 years) received services in local county health departments. This number excludes single service patients [STD-only, Immunization-only, WIC-only]. Additionally, there are 40 full-time, school-based clinics funded through Maternal and Child Health Block Grant funds. These clinic sites are nurse screening and referral models, and provide a variety of health screening services and facilitation of Medicaid enrollment. There are also 175 preventive health sites in schools established through the local health departments and Family Resource/Youth Services Centers (FRYSC) to provide EPSDT and well child services one day per week.

Local health departments participate in a variety of outreach activities. The allocation to local health departments for the Well Child Program (Title V funded) includes monies for conducting outreach to enroll children in preventive care. The outreach service is provided for children under 185% of poverty. Income assessments are performed in all local health department clinics. The income assessments are reviewed for possible Medicaid eligibility. New applications, as well as annual reviews of established patients, are assessed by the local health department intake staff for possible referral for medical assistance through Medicaid.

Local health departments have an agreement with Medicaid for reimbursement to provide the newly eligible Medicaid recipient with information and education on the need for preventive health services for children and the availability of screening services.

Kentucky has nine Federally Qualified Health Clinics (FQHC) and one FQHC look-alike serving the medically needy in the state. Eight of these centers provide outreach in their own capacity and two of the larger facilities have full-time outreach workers. The larger urban centers have departments that link with the community and social services. Eight centers also offer eligibility assistance to their patient population. They have on-site workers who help the patients determine whether they are eligible for Medicaid or any other type of assistance. The patients are then referred to the Department for Social Insurance for enrollment. Medicaid contracts with the Department for Social Insurance (DSI) for Medicaid eligibility determination and enrollment. Outreach within this capacity is done by giving them as much information as possible to ensure that the patient has some health care coverage. Outreach is also conducted informally through nurses, case managers, and social workers. In addition, Kentucky has 61 Rural Health Clinics (RHC) and 87 Primary Care Centers (PCC); most of which are dual licensed RHC/PCC. Many of these centers are owned and operated by hospitals and may also serve as satellite sites for the Community Health Centers in the state.

Currently the Kentucky Department for Mental Health/Mental Retardation Services' role in assisting and obtaining creditable health coverage for children is fairly limited. When a child presents for services at a Community Mental Health Center (CMHC), registration data is collected, including information about family income and insurance coverage. If it is discovered that a child has no insurance and the child appears to be Medicaid eligible, the family is referred to the Department for Social Insurance (DSI) to apply for Medicaid benefits. In addition, CMHC case managers/service coordinators may assist families in completing the steps to apply for Medicaid benefits. Many CMHCs provide training for direct service providers on how to access DSI services. Training is often provided by DSI staff.

Kentucky's First Steps early intervention program serves children from birth to age three who have a developmental delay or a particular medical condition that is known to cause a developmental delay. First Steps has 15 intake offices located throughout the state, one in each Area Development District. In 1997 these offices received 3,677 referrals. It is estimated that 50% of children eligible for First Steps early intervention services are eligible for Medicaid. Intake coordinators visit the families referred and discuss Medicaid eligibility. If the family is not presently in the Medicaid program but appears to be eligible, the coordinator makes an effort to have eligibility determined.

Other possible sources of referral to Medicaid include:
***Hospitals/Physicians/other providers**
***School-based health centers**
***FRYSC - Family Resource/Youth Services Centers**
***County and state social services agencies**
***Commission for Children with Special Health Care Needs**
***Medicaid Managed Care Partnerships**
***Insurance agents**
***Churches**

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

Not Applicable; Kentucky does not have any public-private insurance programs.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Kentucky plans two avenues for children's coverage:

1) The Medicaid program will be expanded to include poverty level children from 14 to 19, and targeted low income children one to 19 with family incomes at or below 150% FPL, and 2) a separate insurance product will be offered to children birth to 19 who are not eligible for the Medicaid program up to 200% FPL. The insurance program will be organizationally located within the Department for Medicaid Services, Cabinet for Health Services.

The application processes and eligibility determination for Medicaid for poverty level children and KCHIP are the same. The application information will be available at numerous sites across Kentucky including The Department for Community Based Service (offices, Health Departments, Family Resource and Youth Service Centers, as well as, other numerous local sites. Applicants can complete a mail-in application form or go to the local DCBS office to apply for benefits. Once the application is processed, an approval notice and medical card or denial notice is generated by a management information system. If the application information is incomplete or required verification is missing, a Request for Information is system-generated, and it remains pending for 30 days or longer, if requested. A complaint system and tracking process are in place should a family have problems with accommodations.

Medicaid outreach is already being conducted at the locations mentioned in Section 2.2.1. With notification of the additional KCHIP coverage, outreach will be conducted at these locations targeting children potentially eligible for the Medicaid expansion or the separate insurance program. In addition, several new outreach efforts will be implemented as a result of KCHIP. These efforts will target all low-income children whether they are eligible for Medicaid or KCHIP separate insurance program. See Section 5 for specific outreach efforts.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

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

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

The service delivery system for the KCHIP Medicaid expansion and the separate insurance program will be the same as for all Medicaid recipients. Medicaid and KCHIP recipients will be mandatorily enrolled in a managed care capitated system with the exception of the region surrounding Louisville (which is served by Passport Healthcare Plan, the Health Care Partnership). Services are provided to Medicaid and KCHIP recipients through a Health Care Partnership in one region of Kentucky. The KenPAC program of PCCM will remain until the program is bid out to a managed care system.

As indicated, KCHIP recipients will be served through the Medicaid service delivery system described in Kentucky's approved Title XIX state plan and relevant approved Medicaid waivers. As the Medicaid service delivery system changes over time, KCHIP recipients will be included in the revised service delivery mechanisms.

Funding 10% for other forms of child health assistance Kentucky realizes it may use up to 10% of actual Federal and State benefit expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for direct services, other health service initiatives to improve children's health, outreach, and administrative costs. Kentucky estimates this amount to be approximately $6.4 million dollars if all federal and state expenditure limits are reached.

Kentucky has received several proposals from a variety of providers, e.g., Title V agencies (primarily local heath departments), to provide specific services designed to improve children's health. These include home visitation programs, school-based nurse programs, health education, and teen pregnancy prevention programs supported by school systems and Title V programs. Similar proposals are being developed by Federally Qualified Health Clinics and providers of specialized children's services or special children's populations.

State KCHIP administrative costs for implementation of the program will come from this same category and are still evolving. Additionally, the amount of these dollars is based on actual funds spent for benefits; it is therefore difficult to estimate the amount of funds available and how these funds will be used at this time. For example, a coalition of organizations is developing statewide to apply for Robert Wood Johnson funding to augment the KCHIP outreach effort described in this plan and to support local demonstration projects. Part of the 10% amount may be used for outreach, should this

application not be chosen for RWJ funding.

Therefore, until more is known about state administrative costs and the amount of funds available, Kentucky will have as its first priority, providing benefits to children. Concurrent with this effort, Kentucky will solicit proposals from the many projects, initiatives, coalitions, and service providers currently serving targeted low-income children. These proposals will be evaluated for receipt of portions of the 10% amount based upon their ability to reach a unique part of the targeted low-income child population or to demonstrate cost-effective strategies for ensuring creditable coverage reaches more of the targeted low-income group.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

The Department for Medicaid Services contract standards will require that participating managed care entities have adequate utilization management staff and procedures to assure that services provided to enrollees are medically necessary and appropriate. The utilization management contract standards will address the contractor's written utilization management program, procedures, staff, timelines, and standards for service denials. National Committee for Quality Assurance (NCQA) and applicable Kentucky managed care regulations and guidelines will be used for development of these standards.

Monitoring compliance with utilization management contract standards will be accomplished as follows: managed care organization program staff will cooperate with the annual on-site review performed by the Kentucky Cabinet for Health Services, who will contract with an external review entity to evaluate utilization management.

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

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

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ Geographic area served by the Plan:

Statewide (Medicaid coverage for poverty level children 14 to 19 in families at or below 100% FPL effective July 1, 1998 and for targeted low income children 1 to 19 in families at or below 150% FPL, effective July 1, 1999, and a separate insurance package for children birth to 19 not eligible for Medicaid and with family income under 200% FPL, effective November 1, 1999. Eligibility standards will be consistent statewide.)

4.1.2. ☒ Age:

Birth to 19 years of age

4.1.3. ☒ Income:

To be eligible for the Medicaid expansion, the children must be from families whose incomes are at or below 150% FPL. To be eligible for the insurance product the children must be from families whose incomes are at or below 200% FPL. Income disregards will be applied to ensure the child is enrolled in the appropriate program. If children are determined to be Medicaid eligible, they cannot be enrolled in the insurance program. Income will be cross-referenced with other programs, which require income verification. See Section 4.3 (See Appendix E).

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

There will not be any resource testing for the insurance program for income eligible Medicaid applicants.

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state):

Medicaid residency requirements will be used for the Medicaid expansion and the separate insurance program.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage:

(See Section 4.4.4)

4.1.8. ☒ Duration of eligibility:

Children are re-certified for eligibility every 12 months. Changes in income, residence, and insurance status must be reported by the family within 10 days and may result in termination of eligibility for KCHIP. Children living in Partnership regions receive 6 months continuous eligibility, as provided by Kentucky's 1115 waiver.

4.1.9. ☒ Other standards (identify and describe):

The parent is requested to provide a social security number and is informed that it is not required if only applying for benefits for the child/ren. The application process is a joint process for Medicaid and KCHIP. A social security number is required for the applicant child consistent with 42 CFR 457.340(b).

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

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

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

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

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

KCHIP will rely on several features to establish eligibility and promote continuing enrollment. It is anticipated that the outreach effort of KCHIP and others will create a pool of potential eligible children (See Section 5). These children will include:

- **Children without insurance but Medicaid eligible,**
- **Children without insurance but with family incomes higher than allowed under Medicaid,**
- **Children whose insurance coverage has been terminated for reasons other than voluntary action by them or their parents, e.g., job loss, coverage changed, death of a**

parent or divorce (See Section 4.4.4.),

- **Children without insurance being served by other health care programs, i.e., WIC, well child, free clinics, federally funded 330 agencies.**

Through eligibility determinations, this pool of potential eligible recipients will be channeled to Medicaid or KCHIP as appropriate. The goal is to make eligibility determination and enrollment into KCHIP as simple as possible for the applicant and plan provider while meeting all statutory requirements of Title XXI.

Kentucky uses a joint application process for KCHIP/Medicaid.

The application can be completed by the parent or another caretaker. Many agencies assist families in determining what information is needed and applications can be downloaded from the KCHIP website, obtained by calling a toll free number, or obtained at a variety of localities throughout the state including the local DCBS office, health departments, physician offices, primary care centers, and hospitals. The local Department for Community Based Service Office will determine eligibility for KCHIP and Medicaid.

If the child is determined eligible for KCHIP/Medicaid, the information will be entered into a management information system and an approval notice and medical card will be generated and mailed.

<u>Recertification</u>

Recertification will be required every 12 months with requirements for recipients to notify the state within 10 days of any changes in financial or coverage status impacting eligibility. If the recipient is determined to be ineligible for the program due to this change, coverage will be discontinued. These changes will include, but not be limited to, change in family income beyond KCHIP eligibility levels, eligibility for Medicaid coverage, or availability of coverage through employer. KCHIP Medicaid expansion, separate insurance program, and Medicaid will reinstitute the use of a mail-in process for recertification of children effective July 1, 2002.

Families will automatically receive a recertification form for KCHIP by mail, or the DCBS caseworker will contact them by phone. The form and verification of income and care giving expenses are to be provided to the local DCBS office.

If recertification is not returned, a second notice is sent. The case is discontinued if the recipient does not respond after two notices. If the recertification form and required documentation is returned to the office within 30 days after the date of discontinuance, the case will be re-determined based on the information received and the family will not need to complete a new application for benefits.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any).
(Section 2106(b)(7)) (42CFR 457.305(b))

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))**

Applicants will be asked if the child has had health insurance coverage within the past 6 months. Enrollment in group health plan or health insurance group health plan or coverage within the last six months may remove the child from the low-income target group. (See Section 4.4.4.1.)

By using a joint Medicaid/KCHIP application process, the child is determined eligible for and enrolled or referred to the appropriate program. If the income and age limitations are not met, the child will be ineligible for either program.

Providers contracting with KCHIP will be required contractually to notify the Department for Medicaid Services whenever they have reason to believe a member has coverage other than KCHIP. The Department for Medicaid Services will then verify coverage with the insurance carrier and notify the family that they will be disenrolled if other coverage is verified.

Children of state employees will be enrolled in KCHIP if they meet all other technical eligibility requirements including income limits and lack of health insurance. Kentucky is electing to cover children of state employees per authority outlined in Section 10203(6)(C) of the Patient Protection and Affordability Care Act. Specifically, this section grants an exception to coverage of children of state employees if the State determines that the annual aggregate amount of premiums and cost sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved. Kentucky determined that the annual amount of cost sharing imposed for all children of state employees who are not otherwise covered by health insurance would exceed 5% of the family's income.

The State has covered children of state employees in KCHIP with 100% state general fund dollars since the inception of KCHIP. Therefore, methodology used to determine hardship criteria for families is based on actual claim data for children of state employees who were enrolled in KCHIP in state fiscal year 2009. State fiscal year 2009 was used because it contained a full year of comprehensive data. Based on claims data for children of state employees enrolled in KCHIP, the state determined an average number of visits per provider type per child. Due to the fact that not every child enrolled utilizes every service and given that the KCHIP benefit package covers many services not available in the

commercial world, the State determined that in order to arrive at a reasonable out-of-pocket amount per family, basic services would be used in the analysis. The services used in analysis and to determine reasonable out-of-pocket costs are: inpatient hospital, physician, pharmacy, preventive, dental, optometry, and EPSDT screening services. A summary of the average utilization of all services is included in a separate attachment labeled Attachment 1.

The State determined the average billed charge for each service utilized by children of state employees. The average billed charge was necessary in order to determine the amount of co-insurance for which state employees would be responsible. The State then determined the amount of co-payment or co-insurance as outlined on the 2010 Kentucky Employees' Health Plan 2010 Benefits Grid and included as Attachment 2.

While it is reasonable to expect that a child may have one hospital visit per year, costs associated with hospital visits were not included in the final analysis. Children of state employees averaged 1 hospital visit per year. Therefore, based on the average hospital billed charges, all families would meet their annual deductible, regardless of the benefit plan in which they were enrolled. In lieu of including costs associated with hospital visits, the annual family deductible was used in cost calculation.

The State summed the co-payments and co-insurance amounts for which the employee would be responsible for in each benefit plan available to them. The sum of co-payments and co-insurance is per child. The annual premium was added to the sum of co-insurance and co-payment amount to determine the average annual out-of-pocket per family. For those programs that provide a health reimbursement account (HRA) or health benefit allowance, the amount of the HRA or allowance was deducted from the annual out-of-pocket total calculated for the family. The sum of the co-payments and co-insurance only was used to determine out-of-pocket expenses for each additional child in a family. This resulted in the deductible and annual premium being used one time in the calculation while the co-payments and co-insurance amount used in the calculation was dependent upon the number of children in the family.

It is the State's contention that the costs that were utilized to determine a reasonable out-of-pocket expense for state employees are very modest and demonstrate that state employees not granted access to KCHIP face financial burdens not experienced by other families who do not work for state government and fall within the same income bracket. Attachment 3 outlines the final calculation methodology used to determine the out-of-pocket expenses for state employee families who participate in the Kentucky Employees' Health Insurance Plan and compares the out-of-pocket to 5% of a family at the upper limit of the 2010 federal poverty level.

The State will continue to monitor whether state employees continue to meet the hardship criteria on an annual basis. The methodology outlined above will be used each year in order to ensure that the out-of-pocket expenses for state employee families who participate in the Kentucky Employees' Health Insurance Plan remain above 5% of their annual

income and, therefore, comply with all federal rules.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX.

(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

Outreach efforts utilizing various community organizations will target low income families with children and provide them with information about the application process. . A joint application process is used to determine eligibility for Medicaid and KCHIP. The DCBS is the agency that does all eligibility determination for the Department for Medicaid Services.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Using a joint Medicaid/KCHIP application process, children determined ineligible for Medicaid are identified for KCHIP, if the income and age limitations are met.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box.
(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The joint Medicaid/KCHIP application process determines whether the applicant has been or is covered under group health benefit plan, and if coverage was terminated in the past six months, why. A person will be ineligible for the KCHIP Medicaid expansion or separate insurance program for targeted low income children if they have group health insurance coverage. If a person has had group health insurance coverage in the prior six month time period, with exceptions noted below, this person is ineligible for the KCHIP separate insurance program, but would be eligible for the Medicaid expansion program. The state will annually evaluate the responses to the question about health insurance coverage other than Medicaid.

The application process will also determine whether the applicant currently has group or individual comprehensive health coverage and will deem the child ineligible if he/she has such coverage. Under the separate insurance program, an application may be approved in cases where coverage ended less than six months prior to determination **of eligibility for KCHIP, if the coverage was terminated for reasons beyond the parent's control, such as:**

1. **Loss of employment,**
2. **Death of a parent,**

3. **Divorce,**
4. **Change of employment,**
5. **Change of address so that no employer-sponsored coverage is available,**
6. **Discontinuation of health benefits to all employees of the applicants employer,**
7. **Expiration of the coverage periods established by the Consolidates Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-272), as amended from time to time,**
8. **Self-employment, and**
9. **Termination of health benefits due to a long term disability.**

This information will be by declaration under penalty of perjury, with selective verification with the family's employers if necessary.

During the initial enrollment process and annual recertification process, income will be cross-referenced with other programs which require income verification.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

There are no federally recognized American Indian Tribes in Kentucky. Outreach efforts are provided to all ethnic backgrounds including American Indians and Alaskan Natives.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:
Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Kentucky's major outreach strategies will be to inform families about the availability of health coverage, assist families in a friendly environment with the eligibility application process, and follow through to enroll eligible children in either KCHIP separate insurance program, KCHIP Medicaid expansion, or Medicaid. All outreach strategies outlined in Section 5 apply to the Medicaid expansion as well as the separate insurance program.

Outreach to families of children who are likely to be eligible for the Title XXI Medicaid expansion or the new KCHIP separate insurance program will include the use of a statewide coalition of children's and advocacy organizations to assist the state in planning and implementing innovative avenues for outreach. Composition of this organization will include the Department for Public Health, Parent Teacher Organizations, state medical and pediatric societies, Head Start, Family Resource/Youth Service Centers (FRYSCs), childcare organizations, and others.

<u>Outreach and Application</u>

A KCHIP/Medicaid joint application process will be used for both Medicaid and KCHIP eligibles. The application process for KCHIP and Medicaid for children can be completed using a mail-in application or through an interview at the local DCBS office. Potential applicants for KCHIP may receive information about the application process, including the information needed to apply, at a number of community health, education and human service agencies.

Qualified applicants ultimately will be enrolled in either KCHIP or Medicaid. DCBS will notify parents if the child qualifies.

Outreach for KCHIP/Medicaid will be conducted in locations frequented by the children and families, with particular focus on people or agencies within the community that have direct contact with potentially eligible children. Some of these encounters could perhaps be as brief as grocery shopping (word of mouth) and others more significant as with the FRYSCs. Our mission is to leave no child behind and to ensure every eligible child a healthy start.

In some instances, outreach may consist of only the dissemination of information about KCHIP and Medicaid and the application process in other locations the emphasis will be on providing assistance to the parent(s) in completing the

application process. This will be done in a child-friendly atmosphere with a comfort level conducive to the process. Also, focus will be placed on enrolling children already eligible for other means-tested programs such as the Free and Reduced School Meal program, Kentucky Education Reform Act (KERA) Pre-School Program, WIC, and Head Start.

Organizations who could provide KCHIP outreach, and application assistance may include the following:

- **Federally Qualified Health Centers (FQHC), Disproportionate Share Hospitals (DSH), Community Health Centers, Community Mental Health Centers, and family planning clinics,**
- **Free Clinics,**
- **Churches,**
- ***Department for Community Based Services (DCBS)**
- **Family Resource/Youth Services Centers,**
- **Location of contracted providers (private physicians' offices, hospitals and others); Medicaid and Temporary Assistance for Needy Families eligibility determination sites at county social service agencies,**
- **Area Development Districts (ADDs),**
- **Job training centers and employment offices,**
- **Other state programs including public schools' Free and Reduced school meal program; the Commission for Children with Special Health Care Needs; the Special Nutritional Program for Women, Infants, and Children (WIC);**
- **Commodity Supplemental Foods Program (CSFP); subsidized housing; and other public health services,**
- **County public health departments,**
- **Public schools through distribution of materials to families in school mailings or newsletters and at back-to-school programs,**
- **Kentucky Homeplace Project, a home visitation program,**
- **University of Kentucky Mobile Dental Program,**
- **Insurance agents,**
- **Kentucky Council on Child Abuse, and,**
- **Kentucky Optometric Association.**

Note – Department for Social Insurance and Department for Social Services have been combined through reorganization and are called Department for Community Based Services.

The level of involvement of these various organizations will be contingent upon the expertise and competency of the staff and their proximity to children and their families. These organizations should have the potential of coming in contact with a large number of children.

Within the first year of plan approval, the KCHIP staff will investigate and finalize specific outreach strategies with the assistance of the statewide coalition described later in this section. The outreach process will be continuously refined for the

purpose of reaching the greatest number of eligibles for both KCHIP and Medicaid.

Special and unique outreach and application assistance will target:

*** Families of migrant workers. KCHIP will work with Kentucky Migrant Education Program, Kentucky Migrant Network Coalition, and the Kentucky Migrant Health Program to develop specific outreach activities for migrants statewide,**
*** Homeless children at homeless health centers and other service agencies for the homeless, and,**
*** Children in rural areas. KCHIP will work with public health nurses, school enrollment campaigns, community/migrant health centers, and private physicians and hospitals that are located throughout the state.**

Through the KCHIP Website, agencies and individuals will be able to access information about KCHIP, including a downloadable application that is available in English and Spanish. The Website information will be updated and changed, periodically.

<u>Outreach and Coordination Strategies</u>
KCHIP will be marketed statewide as a full benefit health plan, following seven primary strategies: 1) direct appeal to eligible families through press releases, broadcast and print media, videos, and brochures; 2) outreach through school districts; 3) outreach through employers; 4) outreach through collaboration with local county agencies and organizations; 5) outreach through regional health and social service agencies; 6) outreach through other state children's programs; and 7) outreach through foundation sponsored coalitions. KCHIP materials will be user friendly and designed for easy reading.

The process must appeal to both the chronically needy who have regular interaction with human service agencies and to the working poor who have traditionally avoided government programs. Outreach techniques will portray KCHIP as a low-cost health plan supported by state government rather than as a government-sponsored program.

Activities to accomplish the outreach strategies are:

1) Direct Appeal to Eligible Families through Press Releases, Public Service Announcements, Videos, and Brochures
Radio and television public service announcements and advertisements will be aired to support mailings of materials to community human service agencies. A toll-free number to call for more information will be featured in the public service announcements, printed materials, and press releases. Frequent news releases will be sent to the press about the increased coverage available. Radio stations, TV and cable stations, Kentucky daily and weekly newspapers and specialty publications

and newsletters for professional associations in the areas of children's health care, parenting, day care and education will receive the press releases.

Outreach methods other than written materials will be employed whenever possible. A video, which explains the KCHIP health plan, will be produced and will be distributed for showing in waiting rooms of providers' offices and eligibility determination sites. All outreach materials will prominently feature the toll-free telephone number. Callers to the toll-free number may hear a recorded message about the plan, speak to a customer service representative, or leave their name and address to receive application information. Bilingual staff or translation services will be available.

2) <u>Outreach through School Districts</u>

KCHIP will collaborate with the Kentucky Department of Education to conduct Back-to-School Enrollment Campaigns in school districts statewide and to develop School-Based Enrollment Projects in selected communities and other outreach programs as determined by the school districts. Schools will verify KCHIP eligibility when applicants are qualified for the meal program through a check off system for parents interested in learning more about KCHIP. The local health department will send information to all interested families. Back-to-school enrollment campaigns will also reach out to eligible families who have not applied for the school meal program. Information will be available to all eligible families through school employees who are most likely to speak with eligible families as determined by the school districts: the health aide, assistant principal, principal, school secretary, PTA contact, social worker, English as a Second Language coordinator, Child Find coordinator, physical education instructor, coach, and the teachers who have particularly close rapport with students and parents.

Information will also be distributed through other sources such as the Head Start Program and meals program. Enrollment kits with fliers and enrollment pamphlets will be mailed to schools identified by the district as interested in helping to conduct KCHIP outreach. Fliers will also be sent home to each family with the school's newsletter.

3) <u>Outreach through Employers</u>

To encourage employers to provide information to employees with uninsured children, KCHIP will include the Kentucky Chamber of Commerce in regional planning meetings, make presentations to local chambers of commerce and business organizations, send press releases to trade publications, and contact employers through direct mail. Encouraging employers to participate in covering dependent children is the cornerstone of the transitional KCHIP approach.

4) <u>Outreach through Collaboration with Local County Agencies and Organizations</u>

In order to involve concerned citizens at the community level, the KCHIP will invite county health departments to host annual regional planning meetings for health care providers, human service agencies, school districts, and community leaders to discuss the health care needs of under-served children in their community and to learn how KCHIP can help. Places of worship and civic groups will be given the opportunity to host informational meetings and provide their membership with KCHIP materials.

Outreach and training sessions on KCHIP eligibility will be conducted for the staff of county public health departments, county social services employees, WIC coordinators, Medicaid case workers, family resource center staff, school nurses, providers, the Commission for Children With Special Health Care Needs, etc.

5) <u>Outreach through Regional Health and Social Service Agencies</u>

KCHIP information will be available at community-based health care providers including Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), community mental health centers, family planning clinics, rural health centers, school based health centers, and residency program family medicine centers.

6) <u>Outreach through Other State Children's Programs</u>

KCHIP continues to coordinate with the following programs to promote KCHIP: school free and reduced school meal program; Special Nutrition Program for Women, Infants and Children (WIC); Commodity Supplemental Foods Program (CSFP); the Commission for Children With Special Health Care Needs; or other public health services. With the cooperation of the county level staff, all children in such a family who are under age 19 can enroll in KCHIP or Medicaid on one short application form.

First Steps is Kentucky's Early Intervention System (KEIS) that serves children birth to age three who have a developmental delay or a particular medical condition that is known to cause a developmental delay. First Steps services are provided statewide and coordinated by the lead agency, Cabinet for Health Services. First Steps has intake coordinators and primary service coordinators in all 15 Area Development Districts. The intake coordinators work closely with local Department for Community Based Services offices when they receive referrals to ensure coordination of outreach with families who may be eligible for Medicaid. Primary service coordinators work with families who are potentially Medicaid eligible to have eligibility determined.

Outreach for the KCHIP and Medicaid will continue to be conducted through Resource Persons and the newly established HANDS (Health Access; Nurturing Developmental Services) programs, home visitation programs for newborns,

administered through local health departments. The Resource Persons and HANDS programs will be combined into one program. Home visitors give new parents KCHIP and Medicaid program brochures and answer questions of new parents. Visitors call parents at times coinciding with the child's immunization schedule to remind parents to have their children immunized and to inform them of the availability of free or reduced price immunizations and health care coverage.

7) <u>Outreach through Foundation Sponsored Coalitions</u>
Health Kentucky, Inc., sponsored by the Kentucky Medical Association and the Good Samaritan Foundation, provides qualified applicants under 100% FPL with free single-visit access to health care providers. Persons who contact Health Kentucky are routinely screened for Medicaid eligibility and will be provided with KCHIP enrollment information as well.

The University of Kentucky Center for Health Services Management and Research, the lead applicant, and other health care and children's organizations, in collaboration with the Cabinet for Health Services (the Title XXI agency) received the Robert Wood Johnson Foundation Grant: Covering Kids: A National Access Initiative for Low-Income, Uninsured Children. The grant facilitates and augments a close working relationship through state and local efforts in three areas: design and conduct of outreach programs that identify and enroll eligible children into Medicaid and KCHIP; simplification of enrollment processes; and coordination of existing coverage programs for low-income children. This coalition covers the entire state and includes: Family Resource/Youth Services Centers; Head Start; Commission for Children With Special Health Care Needs; public health departments; primary care centers; rural health centers; academic health centers; Kentucky Youth Advocates; Kentucky Chapter, American Academy of Pediatrics; Kentucky Hospital Association; Kentucky Medical Association; Kentucky Public Health Association; day care coalitions; school-based groups and other child advocacy groups.

There are a number of outreach efforts that are best accomplished through a coalition. The Kentucky Cabinet for Health Services, as the agency responsible for KCHIP, supports this coalition and will continue to participate and support it regardless of funding decisions made by RWJ.

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

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

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

- 6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)
- 6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

- 6.1.4.1. ☐ Coverage the same as Medicaid State plan
- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage

For children in families with incomes from 150% to 200% FPL, Kentucky will provide a KCHIP benefit package that uses the state Employees HMO as the benchmark plus additional coverage. In Appendix H, a side-by-side comparison of the KCHIP separate insurance program benefits package and the State Employees HMO Plan has been provided. Please see attached.

For children in families with incomes from 150% TO 200% FPL, Kentucky will provide a KCHIP benefit package that will be essentially the same as the State's Title XIX Medicaid plan with the exception of non emergency transportation and EPSDT special services.

Kentucky's EPSDT Special Services coverage includes medically necessary and appropriate health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses, and conditions identified by EPSDT screening services, which are not covered under the Kentucky State Medicaid Plan (Title XIX). Excluded from EPSDT Special Services coverage are any services listed as exclusions in 1905(a), including, but not limited to physical structural changes to a residence, recreational equipment, specified educational tools, including computers, and environmental devices, including air conditioners.

Children with FPL of 150% or above are not eligible for EPSDT services or non-emergent transportation.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490) (Applies to separate program only).**

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**
6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**
6.2.3. ☒ Physician services **(Section 2110(a)(3))**
6.2.4. ☒ Surgical services **(Section 2110(a)(4))**
6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**
6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**
6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**
6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**
6.2.9. ☒ Pre-natal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**
6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**
6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**
6.2.12. ☒ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**
6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**
6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**
6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**
6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**
6.2.17. ☒ Dental services **(Section 2110(a)(17))**

6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**
6.2.19. ☐ Outpatient substance abuse treatment services **(Section 2110(a)(19))**
6.2.20. ☒ Case management services **(Section 2110(a)(20))**
6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**
6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**
6.2.23. ☒ Hospice care **(Section 2110(a)(23))**
6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

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

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards
7.1.2. ☒ Performance measurement
7.1.3. ☒ Information strategies
7.1.4. ☒ Quality improvement strategies

KCHIP will use quality standards, performance measures, information, and quality improvement strategies to assure high-quality care for KCHIP enrollees. KCHIP will be incorporated into Kentucky's Health Care Partnerships. They will use quality assurance methods and tools such as NCQA accreditation standards, Health Plan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plan Survey (CAHPS) data and/or other quality improvement data. The standards used will be adapted from the 1115 Waiver required of the Medicaid managed care Partnership's entities. This will allow comparisons across provider and patient cohorts. Quality measures will be required of all managed care entity contractors and sub-contractors providing coverage and services to the KCHIP children.

CAHPS is utilized for the KCHIP population under the PCCM and managed care system. The state is administering and analyzing the CAHPS questionnaire for families enrolled in KCHIP. The KenPAC program of PCCM will remain until the program is bid out to a full managed care system. CAHPS and HEDIS will also be utilized when the population is bid out to a managed care program.

Access and utilization data are also maintained for PCCM and the managed care system. The state is analyzing claims data to evaluate access and utilization by children in PCCM and Managed Care, by regions of the state and by age.

EPSDT administrative data are collected through new codes developed for providers to record recipient encounters. These codes are used by PCCM providers and managed care organizations; thus, the state can generate EPSDT data for both KCHIP enrolled children in PCCM and Managed Care.

Immunizations are more difficult to track for KCHIP children under PCCM. The Department for Medicaid Services has been discussing alternative solutions to improving data collection and retention of records for immunizations with the Department for Public

Health. No long-term solutions have been identified, and there is no statewide registry. Administrative data are used for tracking, but using this data source is problematic. Currently, Kentucky ranks third in the nation on the percentage of children ages 19 to 35 months (88.6%) who have been immunized. This is based on the National Immunization Survey implemented by CDC in 1994, which began tracking immunizations in Kentucky in 1995.

Quality improvement strategies for the primary care case management program, KenPAC, will include methods and tools such as: CAHPS; access and utilization data on birth outcomes, EPSDT, immunizations and other selected performance measures; and selected quality studies. Quality study designs will be based on methods developed by NCQA.

The Department for Medicaid Services (DMS) has established two advisory groups to provide input to the Divisions responsible for quality improvement in Medicaid and KCHIP. The two groups are; the Quality Improvement Advisory Council (QIAC) and the KCHIP Advisory Council. Also, there is an interagency quality improvement team to promote coordination, communication and implementation within the DMS.

The managed care entities must have a Consumer Advisory Committee who report to The Quality Improvement Advisory Council. They review member handbooks and educational materials, issues related to quality and access to covered services, and complaints. The Quality Improvement Council also reviews and advises on quality standards, grievances and appeals, and makes recommendations on incentives and policies that affect managed care entities. Authority for the Quality Improvement Council is 907 KAR 1:705. The KCHIP Advisory Council also reviews and advises on quality standards and improvement strategies.

The KCHIP Branch in coordination with the Division of Quality participates on the Quality Improvement Interagency Team. This team reviews and provides input on clinical studies, benchmarks and outcome measures, annual member and provider satisfaction surveys, and the design, implementation and analysis of studies conducted by research entities.

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

Under the KenPAC (PCCM) program, the recipients' primary care providers manage access to well-baby care, well-child care, and well-adolescent care. In addition, the Department for Medicaid Services assesses access to care, evaluates the member and provider complaints, grievances, appeals and denials of care for KenPAC. They review member education materials, provider credentials and practice issues, suspected cases of potential fraud and abuse, and monitor primary care provider assignments. The KenPAC program of PCCM will remain until the program is bid out to a managed care

system.

Both KenPAC and managed care entities will solicit input through the committees comprised of providers, advocates and parents of children eligible for the program.

Managed care entities are required to demonstrate adequate provider networks and access to care prior to contract award and through periodic reporting, with monitoring by the Department for Medicaid Services.

The Department for Medicaid Services conducts an annual patient satisfaction survey, CAHPS, to KCHIP recipients.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

Emergency services are monitored in the same manner as 7.2.1.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Enrollees with chronic, complex, or serious medical conditions may either have a medical home through enrollment in Passport Health Plan or the KenPAC program, or may be served through fee-for-service Medicaid. The Department for Medicaid Services routinely monitors services provided by Passport Health Plan, including management of enrollees with chronic, complex, or serious medical conditions, through review and follow-up of regular written reports, review and follow-up of complaint data, and on site reviews. Families, care coordinators, service providers and advocates monitor access to care for children with serious medical conditions. The Department relies primarily on complaints and grievances to track the population for KenPAC and fee-for-service enrollees. The KenPAC program of PCCM will remain until the program is bid out to a managed care system.

7.2.3 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patients, within 14 days after the receipt of a request for services.

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

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

8.1. Is cost sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES
8.1.2. ☐ NO**, skip to question 8.8.**

8.2. Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

Not Applicable

8.2.2. Deductibles:

Not Applicable

8.2.3. Coinsurance or copayments:

All enrollees will be subject to the following copayments: $1, $2, or $3 for prescriptions, $2 for office visit and testing for allergy services, and 5 percent of cost of service/co-insurance for non-emergency use of emergency room. $ 1 will be for preferred generics, $2 will be preferred brands and $3 is for non-preferred drugs. The total out of pocket medical costs will be capped at $225 per 12 months and total pharmacy out of pocket maximum will be capped at $225 per 12 months.

Exemptions are: pregnant women through 60-day postpartum period, residents of nursing homes, personal care homes, family care homes and intermediate care facilities for people with mental retardation, hospice patients, foster care children, American Indians/Alaskan Natives and enrollees receiving contraceptives. Passport Health Plan, Kentucky's managed care partnership, began collecting these same co-payments, with the same recipient exemptions, in June 2003. Passport is not required to have providers collect co-payments on all identified services, but they can only consider those amounts identified herein. The capitated rate paid to managed care entities will be reduced by the amount of projected copayments.
Other:

Not Applicable

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

Enrollees will receive a letter notifying them at least ten (10) days prior to the implementation of co-payments for services. This same methodology will also be used to notify enrollees of any future changes in cost sharing amounts or services subject to cost sharing.

Applicants receive information about cost sharing when they apply from the eligibility determination caseworker. There are educational materials available in the local Department for Community Based Services offices where applicants go to apply for services that explain co-pays and premiums.

Providers also receive a letter at least ten (10) days prior to implementation explaining the co-payment and premium policies. This information is also included on the Department for Medicaid Services and KCHIP web sites, which providers routinely use to review current information.

The public schedule and cumulative cost sharing maximums, have been provided to applicants, enrollees, re-enrollees, providers and the general public through a number of activities. Kentucky involved numerous advocacy groups, consumers and legislators in the development of the Family Choices plan. Additional notice activities include advertising in the State's major newspapers, announcing the information at advisory council and advocacy group meetings, holding public hearings on the proposed changes, working with advocacy groups to disseminate the information, announcement and discussion at legislative committee meetings which are open to the public, distributing news releases, posting the information on the Department for Medicaid Services and KCHIP web sites, conducting statewide eligibility and outreach worker training, and publishing and distributing educational information.

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

8.4.1. ☒ Cost sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not

primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

It is not anticipated that cost sharing will exceed 5 percent of the family's annual income for any family with enrolled children. The total amount of cost sharing for both medical and pharmacy services will not exceed $450.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

Kentucky will rely on self-reporting to ensure American Indian and Alaskan Native children are excluded from cost sharing. During the application process in the local DCBS office the worker asks the recipient their race/ethnicity. The computer system automatically generates the medical card for American Indians or Alaska Natives without an indicator requiring co-pays. The eligibility on-line system automatically exempts anyone identifying herself or himself, as American Indian or Alaskan Native. Cards for all American Indians and Alaskan Natives that were active members at the time the policy went into effect were also automatically generated without the indicator requiring the co-payment.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**
- ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements.

(Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

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

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Strategic Objectives and Performance Goals for the Plan Administration

These goals have been developed in conjunction with "Healthy Kentuckians 2000 and updated for 2010", Kentucky's response to "National Health Promotion and Disease Prevention Objectives." As indicated, the following objectives and goals are to be completed within one, two or five years of plan approval and implementation.

Objectives for increasing extent of coverage

1) **Increase the number of children from birth to 19 who are enrolled in Medicaid.**
2) **Improve the health status of Kentucky children with a focus on preventive and early primary care.**
3) **Increase the proportion of children in Kentucky who have creditable health insurance and therefore a usual source of care.**
4) **Reduce the financial barriers to affordable health care coverage for low-income families.**
5) **KCHIP will be available to all eligible children statewide within one year of plan approval.**

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

Performance Goal for Each Objective

Within two years of plan approval and implementation, increase Medicaid enrollment

1) **10,000 new 14 to 19 year olds in families up to 100% FPL will be covered by Medicaid by June 30, 2000, and 17,500 new children from one to 19 years of age in families up to 150% FPL will be covered by Medicaid by June 30, 2000.**
2) **An additional 10,000 currently Medicaid eligible children will be enrolled in Medicaid within two years of plan approval and implementation.**

3) **Within five years of plan approval and implementation, increase health status of children**
    a) **75% of children under 2 years of age will receive the recommended number of well child visits,**
    b) **67% of children from 3 through 5 years of age will receive at least one well child exam (Healthy Kentuckians goal = 80%),**

c) 50% of children from 10 through 18 years of age will receive at least one well child exam annually (Healthy Kentuckians goal = 50%),

d) 75% children will receive an eye exam by an eye care specialist between age 3-6.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Performance Measurement:
The following measurements will be used to measure progress towards performance objectives:
The managed care entities will be encouraged to submit HEDIS 3.0. Administrative data on well child visits and immunizations and patient satisfaction information will be collected and analyzed on children covered by KCHIP.

The managed care entities are required to provide HEDIS data reports on well child visits and immunizations that are submitted on a quarterly and annual basis, but the managed care entities are not required to be NCQA accredited.

Additionally, the following means will be used to evaluate performance objective progress.

Increase Medicaid enrollment:

1) Medicaid Eligibility System Report.

Increase health status of children:

2) HEDIS 3.0 or identified performance measures will be tracked through administrative data.

Percentage of well child care and adolescent well care visits will be determined through administrative data. The established claims data system will enable KCHIP to track for the percentage of visits. It is possible to track for periodicity, but the data is not readily available.

Increase numbers of kids with creditable coverage:

3) Medicaid and KCHIP enrollment data benchmarks.

4) Legislative Research Commission annual insurance studies.

The study uses calculated averages from a three year average, March supplement to the CPS produced by Bureau of Census and augmented by LRC household survey.

Reduce barriers to affordable health coverage:

5) KCHIP will report on enrollees by family income level. Clients who disenroll before their eligibility expires will be asked for a reason. Responses to that question will be tracked and analyzed to evaluate the extent that KCHIP has reduced financial barriers to affordable health care coverage.

Provide statewide coverage:

6) Cabinet KCHIP Annual Report.

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

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well-child care
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☐ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

- 9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

The development of the Kentucky Children's Health Insurance Program has been an open and inclusive process from its origin in November, 1996. At that time the Universal Access Workgroup was convened by staff from the Health Policy Development Branch in the Department for Public Health at the request of the Secretary of the Cabinet Its membership is included in Appendix K. The purpose of the group was to develop recommendations for improving access to health care for several groups consisting of children, adults (working poor), and the elderly without drug benefits.

Work began in several areas, including types of programs possible, the financing of such programs, and the scope of the problem to be solved. As the Balanced Budget Act of 1997 made children's health insurance funding a reality, the workgroup expanded to begin the process of program design. Committees on benefits and finance were established in the fall of 1997 (See Appendix K, KCHIP Planning Participants). These groups were responsible for developing recommendations regarding funding sources for the state match and benefit

package to be used. (See Appendix L, KCHIP Meeting Minutes).

As the benefit plan became finalized, other groups were established to provide recommendations on selective parts of the Title XXI state plan development. An employer group was also established to discuss the opportunities and challenges in developing an employer subsidy program. Membership of these groups is also found in Appendix K.

The state's enabling legislation for the implementation of KCHIP provides for a seven member advisory council appointed by the Governor and ensures ongoing public involvement. This council is comprised of health care providers, families with children eligible for KCHIP and child advocates. Meetings are held on a regularly scheduled basis and upon call of the Chair. All meetings are in accordance with the requirements of the Kentucky Open Meetings Law. These ongoing meetings give members and the public an opportunity to learn about and comment on proposed changes in KCHIP, to identify problems, and to advise and make recommendations.

Ongoing public involvement is also ensured through the regulatory process. When regulations are changed a legislative committee provides review and oversight, and public hearings are held.

In terms of the development of the Family Choices plan, public involvement was paramount in creating buy-in from advocates, consumers and legislators. Kentucky has made a conscientious effort to ensure public input during both the development of the program and the CMS negotiation process. As such, we have continued to participate in numerous public meetings regarding the waiver. During the last three months members of DMS leadership team have met with the following groups:

a. **Advocates for Reform of Medicaid Services (ARMS)**
b. **Brain Injury Provider Group**
c. **Kentucky Association of Private Providers (KAPP)**
d. **Kentucky Alliance of Regional Programs (KARP)**
e. **Medicaid Consortium**
f. **Mental Health Consumer Council**

Following our meeting with CMS in November, we conducted a briefing with the team assisting Kentucky with our Medicaid transformation, KyHealth Choices, which is comprised of consumers and representatives from various advocacy organizations. Members of that team were specifically selected to ensure the dissemination of information to consumers and family members across the state. An additional meeting is scheduled this week to go over the financial sections of the waiver as it pertains to recent CMS discussions.

Additionally, numerous presentations were made to various legislative health and welfare committees as well as with individual Kentucky legislators from both the house and senate.

In anticipation of final CMS approval and recognizing our ambitious timeline, the Commonwealth has undertaken steps to ensure judicious implementation of KyHealth Choices

by creating teams for various strategic components.

During the past few months, several organizations have submitted various documents often referred to as "white papers" as to their suggestions for improving current regulations and policies as we move toward implementation of KyHealth Choices. We have accumulated these documents and utilize the transformation team of advocates, providers and consumers to work through each area, reach a consensus on a response and make recommendations to the Cabinet.

Finally, we have had numerous individual meetings with person and/or organizations wishing to express their views or ask questions.

Kentucky genuinely values public input and finds it to be very helpful to see KyHealth Choices through other eyes. By utilizing the multiple team approach, we are creating a process that will ensure public input not only during the development and negotiation phase of KyHealth Choices but through the entirety of transformation project.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Kentucky has no registered Indian Tribes or recognized American Indian/Alaskan Native groups or organizations. Therefore, no interactive process has been developed. If Kentucky gains a recognized tribe, group or organization an interactive process will be developed.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

Enrollees will receive a letter notifying them at least ten (10) days prior to the implementation of co-payments for services. This same methodology will also be used to notify enrollees of any future changes in cost sharing amounts or services subject to cost sharing.

Applicants receive information about cost sharing when they apply from the eligibility determination caseworker. There are educational materials available in the local Department for Community Based Services offices where applicants go to apply for services that explain co-pays.

Providers also receive a letter at least ten (10) days prior to implementation explaining the co-payment policies. This information is also included on the Department for Medicaid Services and KCHIP web sites, which providers routinely use to review current information.

The public schedule and cumulative cost sharing maximums, have been provided to applicants, enrollees, re-enrollees, providers and the general public through a number of activities. Kentucky involved numerous advocacy groups, consumers and legislators in the development of the Family Choices plan. Additional notice activities include advertising in the State's major newspapers, announcing the information at advisory council and advocacy group meetings, holding public hearings on the proposed changes, working with advocacy groups to disseminate the information, announcement and discussion at legislative committee meetings which are open to the public, distributing news releases, posting the information on the Department for Medicaid Services and KCHIP web sites, conducting statewide eligibility and outreach worker training, and publishing and distributing educational information.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

Revised Budget

STATE: Kentucky

Federal Fiscal Year 2011

	Federal Fiscal Year Costs	Revised Federal Fiscal Year Costs to Include Children of State Employees
Enhanced FMAP rate	**80.04%**	**80.04%**
Benefit Costs		
Insurance payments		
Managed care	$ 33,017,402.00	$ 33,370,202.00
per member/per month rate @ # of eligibles	$ 196.00	$ 196.00
Fee for Service	$ 130,272,352.00	$ 132,419,552.00
Total Benefit Costs	**$ 163,289,754.00**	**$ 165,789,754.00**
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	$ 163,289,754.00	$ 165,789,754.00
Administration Costs		
Personnel	$ 280,200.00	$ 280,200.00
General administration	$ 2,756,300.00	$ 2,756,300.00
Contractors/Brokers (e.g., enrollment contractors)	$ 210,300.00	$ 210,300.00
Claims Processing		
Outreach/marketing costs	Included in general administration costs	Included in general administration costs
Other		
Total Administration Costs	$ 3,246,800.00	$ 3,246,800.00
10% Administrative Cost Ceiling	$ 360,755.56	$ 360,755.56
Federal Share (multiplied by enh-FMAP rate)	$ 133,295,857.82	$ 135,296,857.82
State Share	$ 33,240,696.18	$ 33,739,696.18
TOTAL PROGRAM COSTS	$ 166,536,554.00	$ 169,036,554.00

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Source of state share: state general fund dollars

Approximately 750 children of state employees are currently enrolled in KCHIP. The budget impact of this SPA is anticipated to be approximately $2.5 million based on current trends for services provided to children of State employees. Currently, services are paid for with 100% state federal fund dollars. Approval of this SPA will allow the State to receive the federal participation match for services provided to children of State employees. Approval of this SPA will not increase administrative expenditures.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

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

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. **Program Integrity (Section 2101(a))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** The *items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

The review process for eligibility and enrollment matters for the Kentucky Children's Health Insurance Program, Medicaid expansion program and separate insurance program is described in 907 KAR 1:560 – Medicaid hearings and appeals regarding eligibility and in 907 KAR 1:705 – demonstration project: services provided through regional managed care partnerships. These regulations are incorporated in the regulations governing the SCHIP Medicaid expansion program (907 KAR 4:020) and the SCHIP separate insurance program (907 KAR 4:030). A copy of 907 KAR 1:560 is attached in Appendix M.

Health Services Matters

12.2 Please describe the review process for **health services matters** that comply with 42 CFR 457.1120.

The review process for health service matters for the Kentucky Children's Health Insurance Program, Medicaid expansion program and separate insurance program is described in 907 KAR 1:563 – Medicaid covered services hearings and appeals and in 907 KAR 1:705 – demonstration project: services provided through regional managed care partnerships. These regulations are incorporated in the regulations governing the SCHIP Medicaid expansion program (907 KAR 4:020) and the SCHIP separate insurance program (907 KAR 4:030). A copy of 907 KAR 1:563 is attached in Appendix M.

Premium Assistance Programs

12.2 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable

Family Choices Appendix H

The Family Choices benefit package was based on the Kentucky state employee benefit package with modifications to assure nominal cost sharing. Some benefit limit and design changes were also made to the package. Limits imposed under the Family Choices plan are soft limits which means additional visits may be authorized if medically necessary; in contrast, the limits in the state employee health benefit plan are hard limits and may not be exceeded. The differences are detailed in the following table:

State Employee Benefit	**Family Choices Benefit**
Chiropractic Services- 26 per visits per year	Chiropractic Services- 26 visits per year
Speech Therapy- 30 visits per year	Speech Therapy
Physical Therapy- 30 visits per year	Physical Therapy
Occupational Therapy- 30 visits per year	Occupational Therapy
EPSDT (not fully covered)	EPSDT
Home Health- limited to 60 visits per year	Home Health-
Skilled Nursing Facility Services- limited to 30 days per year	Skilled Nursing Facility Services- no day limitation

The Following table outlines the benefit package for Family Choices. The cost sharing requirements listed in this benefit grid will apply to all members of Family Choices. For the Family Choices populations, these cost sharing requirements shall supersede any other cost sharing requirements described elsewhere in the state plan.

Family Choices

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children – Medicaid Expansion Program	KCHIP Children – Separate Chip Program
Medical Out-of-Pocket Maximum	$225 per 12 months	$225 per 12 months	$225 per 12 months	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	$225 per 12 months	$225 per 12 months	$225 per 12 months	$225 per 12 months
Acute Inpatient Hospital Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Laboratory, Diagnostic and Radiology Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Outpatient Hospital/ Ambulatory Surgical Centers	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Physician Office Services*	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Behavioral Health Services**	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Allergy Services	$0 co-pay	$0 co-pay	• $2 co-pay for office visit and testing • $0 co-pay for injections	• $2 co-pay for office visit and testing • $0 co-pay for injections
Preventive Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Emergency Ambulance	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Dental Services Including but not limited to two cleanings per 12 months, one set of x-rays per 12 months and extractions	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Family Planning	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Occupational Therapy	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children – Medicaid Expansion Program	KCHIP Children – Separate Chip Program
Physical Therapy	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Speech Therapy	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Hospice (non-institutional)	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Non-Emergency Transportation	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Chiropractic Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Prescription Drugs	$0 co-pay	$0 co-pay	$1 generic $2 preferred $3 non-preferred brand prescriptions	$1 generic $2 preferred $3 non-preferred brand prescriptions
Emergency Room	$0 co-pay	$0 co-pay	5% coinsurance for non-emergency use	5% coinsurance for non-emergency use
Hearing Aids $1,400 maximum per ear every 36 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Audiometric Services One audiologist visit per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Vision Services $400 maximum on eyewear per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Prosthetic Devices $1,500 maximum per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children – Medicaid Expansion Program	KCHIP Children – Separate Chip Program
Home Health Services Limited to 25 visits per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
DME	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Early Periodic Screening and Diagnosis (EPSD)	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Treatment (T) Services for Conditions Identified Through Early Periodic Screening and Diagnosis (EPSDT)	$0 co-pay	$0 co-pay	$0 co-pay	Not Covered
Substance Abuse EPSDT only	$0 co-pay	$0 co-pay	$0 co-pay	Not Covered

* **Physician Office Services** includes physicians, certified pediatric and family nurse practitioners, nurse midwives, FQHCs, rural health clinics (RHCs), primary care centers (PCCs) and physician assistants.
Behavioral Health Services include mental health rehab/stabilization, behavioral support, psychological services and inpatient psychiatric services.