OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

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 Children's Health Insurance Program (CHIP). 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.

Form CMS-R-211

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

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

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

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

Kari Bruffett
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved 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)):

Name: Susan Mosier, M.D.	Position/Title: Medicaid Director
Name: Wayne Wallace, M.D.	Position/Title: Acting Medical Director
Name: Michael Randol	Position/Title: Fiscal Manager

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

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.

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))**

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)**

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, 2010
Implementation date: July 1, 2010

Amendment #1 – Effective April 20, 2000
Amendment #2 – Effective May 1, 2001
Amendment #3 – Effective August 21, 2001
Amendment #4 – Effective January 1, 2003
Amendment #5 – Effective July 1, 2003
Amendment #6 – Effective July 1, 2005
Amendment #7 – Effective July 1, 2006
Amendment #8 – Effective January 1, 2010
Amendment #9 – ~~Pending~~ Withdrawn February 6, 2013
Amendment #10-~~Pending~~ Effective November 19, 2010

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Tribal Consultation for KanCare was conducted in two rounds of consultation, an initial consultation meeting in February 2012, and the second in June and July 2012. The State incorporated feedback from the consultation process in its August 6 application for an 1115 waiver. Additionally, a result of the consultation process for KanCare was the establishment of a Kansas Tribal Technical Advisory Group (TTAG) that meets and consults on Medicaid/KanCare issues, including the 1115 authority, 1915(c) waivers, and any other KanCare related authorities on an ongoing basis.

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))**

From 1997 to today, certain studies and reports have been promulgated regarding the uninsured in Kansas. In summary, those are:

September 1997 - The Kansas Health Foundation and the Kansas Department of Health and Environment funded a statewide survey and review of secondary data on insurance coverage. That survey found that 9.4% of the nonelderly population in Kansas was uninsured, and that 31% of the uninsured were children under age 18 (approximately 64,200 children, based on the 1994 Census figures) who were without insurance at the time of the survey. Another 29.9% of those uninsured at some point during the prior year (approximately 25,700) were in this age group. This results in a range of uninsurance for this age group of 64,200 at a point in time to 89,900 at any time over the past year. Adding children aged 18 to this review would, by interpolation, increase the range of uninsured to 67,800 to 91,500.

CPS data from 1993, 1994, 1995 - This data is the basis for the CHIP allocations in FFY 1998. While not statistically significant for Kansas, it showed that there were 60,000 uninsured children under age 19, plus or minus 12,300, for a range of 47,700 to 72,300 children.

March 2001 - Kansas Health Institute Issue Brief 11 - As part of the three-year evaluation of HealthWave 21, the dynamics of the Title 21 and Title 19 programs between July 1, 1998 and June 30, 2000 were evaluated. One of the findings was a majority (68%) of children

entering HealthWave 21 had prior experience with Medicaid, and only 19% to 30% of enrollees were new to public insurance. This implies that while children "aging out" of the stair-step Medicaid eligibility ladder still have access to no-cost or low-cost insurance, the program is not reaching as many of the previously uninsured as was anticipated.

August 2001 - Kansas Health Insurance Study - This study, commissioned by the Kansas Insurance Department and funded by a grant from the Health Resources and Services Administration, Department of Health and Human Services, looked at insurance status by age, gender, marital status, education, employment status, and region. Questions about the reasons for uninsurance and health status were asked. This study found that 7.8% of children under age 19 were not insured at the time of the survey. While this percentage is lower than that found in the August 1997 survey for children under age 18 (9.4% versus 7.8%), it translates into approximately 55,600 children, based on the 2000 population figures for Kansas from the Census Bureau.

Other notable findings were that children were enrolled in Medicaid/HealthWave 21 at three times the rate of the general public, and that the main reason for uninsurance was the cost.

PROJECTED BASED ON 1997 CPS DATA

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

In October 2012, the Georgetown University Health Policy Institute, Center for Children and Families, published "Uninsured Children 2009-2011: Charting the Nations Progress". Using data from the American Community Survey, the report examines trends in children's coverage over a two year period, from 2009-2011. In 2009, the number of uninsured children under age 18 in Kansas was 57,717, in 2011, the number of uninsured children was 46, 345. During this time period the total change in percent of uninsured children under 18 shows a decrease of 1.8 percentage points, tying Kansas for 7th in the nation.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

The Division of Health Care Finance will consult and obtain feedback from the Indian Health Clinic Directors and/or Tribal contacts, prior to implementation of any state plan amendments, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. The process includes the following:

- The Agency will seek advice concerning changes that have a direct impact on Indians, Indian health programs, or Urban Indian Organizations. For example, such changes may be items such as more restrictive eligibility determinations, changes to reduce payment rates or changes in payment methods, or covered services and changes in consultation policies.

- Advice will be sought through phone calls and emails directly to the Kansas Indian Health Services and urban Indian (I/T/Us) Programs.

- Documents relevant to the proposed change will be shared for comments and advice through email. The Indian organizations will not be required to provide input should they choose not to.

- If Indian organizations, desire to have a face-to-face meeting, or conference call concerning the proposed change, such meetings will be arranged.

Section 3. Methods of Delivery and Utilization Controls

☐ 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.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.
If applicable, address how the new arrangements under Title XXI will work with

existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

3.1. **Delivery Standards** 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))

By state statute, service delivery for the CHIP program is provided through capitated managed care arrangements. Other health services are obtained through direct contracts with MCOs chosen for participation as a result of a competitive Request for Proposal (RFP) process. The program is statewide, with coverage and access requirements contained in the contracts and monitored by the state.

Effective with Dates of Service on or after October 1, 2009, Kansas will ensure the Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will receive a reimbursement equivalent to that received by those providers under the Medicaid Prospective Payment System (PPS).

For FQHC and RHC services, CHIP encounter claims are included in the clinic reimbursement method in the same manner as Medicaid encounter claims. Effective January 1, 2001, the State implemented the prospective payment system (PPS) to conform with the Benefits Improvements and Protections Act (BIPA) of 2000. There are no retroactive settlements under the PPS system. As an alternative to PPS, providers are offered the opportunity for reimbursement under the rebased PPS. The rebased PPS averages the two most recent finalized cost settlement rates and applies the MEI trend to the rate. This reimbursement method provides the monies on a current basis rather than retroactive. Clinics are paid the greater of rebased PPS or PPS-based reimbursement.

CHIP encounters in Indian Health Clinics are reimbursed by the managed care organizations at 100% of the Medicare Indian Health Service encounter rate negating the need for a wraparound payment. The managed care organizations reimburse all such managed care encounters provided for enrolled member by the Indian Health Clinic using 100% of the Medicare Indian Health Service encounter rate.

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are 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.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

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))

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

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

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

Children who are determined presumptively eligible for Title XXI will receive the Title XXI benefit package until such time as eligibility for Title XXI is confirmed or denied. The State of Kansas provides Secretary Approved Coverage for Title XXI eligibles which includes the State Employee Health Plan as the benchmark coverage plus additional coverage that is medically necessary.

When formal determination of the PE application is complete, the child will be enrolled in the appropriate program, either Title XIX or Title XXI. Program placement will be based on established eligibility criteria.

Children who are found presumptively eligible for Title XIX will receive the Title XIX benefit package. Title XIX offers services to persons eligible for Medicaid through a managed care organization system. These services are available statewide. Access to medically necessary services are provided by the beneficiaries' MCO.

Claims for services being provided to individuals found to be presumptively eligible for CHIP will be processed in accordance with the State Medicaid Manual, Option 1 (report all expenditures at Medicaid match rate). Applicants who qualify at or under 250% of the 2008 Federal Poverty Guidelines must not have had any active health insurance for the time period of the application date minus 8 months.

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:** The plan is available statewide.

4.1.2. ☒ **Age:** Children from birth to age 19 are served.

4.1.3. ☒ **Income:** Income is at or ~~below 241% FPL~~ under 250% of the 2008 Federal Poverty Guidelines for the CHIP program. Current Medicaid definitions of family income and those income deductions, disregards, and budgeting methods specified in the State's Title XIX State Plan is applicable to the CHIP population

4.1.4. ☐ **Resources (including any standards relating to spend downs and disposition of resources):** No resource test is applied.

4.1.5. ☒ **Residency (so long as residency requirement is not based on length of time in state):** Children must be residents of Kansas. The citizenship and immigration status requirements applicable to Title XIX shall also be applicable to CHIP.

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

4.1.7. ☒ **Access to or coverage under other health coverage:** Children up to 200% Federal Poverty Level are ineligible for CHIP if currently covered by other health insurance or eligible for Medicaid coverage. Children from ~~201 – 241% Federal Poverty Level~~ under 250% of the 2008 Federal Poverty Guidelines may not have had insurance coverage for the time identified time period prior to the application date. The identified time period is eight months.

4.1.8. ☒ **Duration of eligibility:** Annual eligibility determination. Twelve months of continuous eligibility is also applicable to both Title XIX and CHIP even if family income increases above the income threshold.

4.1.9. ☒ **Other standards (identify and describe):**

- To be eligible for CHIP coverage, families above 150% of the poverty level must agree to pay a monthly premium which does not exceed the limitations of section 2103(e).
- Children are ineligible for CHIP coverage if they are eligible for health coverage under the Kansas Group Health Insurance Program, if they are an inmate in a public correctional institution, or if they are a patient in an institution for mental diseases.
- The state requires a social security number for all applicants in accordance with the provisions at 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)**

A simplified application/enrollment form is used to access both Medicaid and CHIP coverage. The form is available through a number of access points including schools, churches, medical providers and ~~Social and Rehabilitation Services (SRS)~~Department for Children and Families (DCF). The form is mailed in along with supporting documentation such as wage information to a central clearinghouse. The clearinghouse is responsible for initial processing and eligibility determination for both Medicaid and CHIP and involves privately contracted staff. The Medicaid state agency administers the portion of the clearinghouse responsible for Medicaid determination and case maintenance. Contracted staff is responsible for all CHIP processing and determinations as well as ongoing case management.

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

Eligibility is continuous for 12 months and re-established annually. The family must meet all eligibility criteria and have paid any applicable premiums from the prior year to be re-enrolled for a new 12-month period. The amendment effective 1/1/99 allows an infant born to a ~~HealthWave~~ KanCare enrolled mother will be retroactively enrolled in ~~HealthWave~~ KanCare starting with the month of birth, but will be subject to Medicaid screening and enrollment requirements no later than 90 days from the date the Agency has been notified of the birth of the infant.

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

If application is made for medical assistance under Medicaid or CHIP, the applicant must provide approved documentation for verification of citizenship and identity.

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

The amendment effective 7/1/01 allows children who had health coverage within six months prior to application for the CHIP program to receive benefits. They will be denied benefits in the situation when other private health coverage is active on the day of application. Kansas does track those who had health coverage within 6 months prior to application. Premiums will be charged to families above 150% of FPL in the CHIP program. There are exceptions which are listed in section 4.4.4.2.

The agency will verify the applicant is not covered by any insurance at the time of application and will monitor any conditions that may contribute to crowd out on at least an annual basis for up to 200% of Federal Poverty Level. For those applicants ~~between 201% - 241% of Federal Poverty Level,~~ under 250% of the 2008 Federal Poverty Guidelines the agency will require that private insurance has not been voluntarily terminated within the previous eight months.

Once determined eligible for the CHIP program, children are enrolled into one of three Managed Care Organizations contracted to provide services. Once approval is authorized in the state's eligibility system, the record is transferred to the MMIS, which in turn sends an 834 enrollment record to the MCO. Applicants may choose any of the MCO's in which to enroll, however if a choice is not indicated on the application the beneficiary will be auto-assigned to an MCO. There is a 90 day choice period after enrollment during which beneficiaries may chose a different MCO. Once the 90 day choice period is over, the beneficiary remains assigned to the plan for one year.

Presumptive Eligibility Process

Staff of designated entities selected and trained by the Medicaid state agency are authorized to determine presumptive eligibility. The determination will be completed using only the Kansas Presumptive Eligibility determination tool. The tool will be provided by the agency. If the income of the family group is at or below ~~241% of the appropriate federal poverty level,~~ 250% of the 2008 Federal Poverty Guidelines the child is presumptively eligible for medical coverage. Children within the CHIP income guidelines may be eligible for medical coverage if he or she has no other health coverage. Information on eligible children will be submitted by the qualified entity to the central clearinghouse within 5 working days. The staff at the designated entity will assist the family in completing a formal application for CHIP and submit it to the central clearinghouse.

Presumptive eligibility begins on the day the designated entity determines that the child appears eligible. If an application is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day a final determination of eligibility is made. If an application is not filed by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Each child is eligible for only one period of presumptive eligibility within a 12 month period. The 12 month period begins on the first day of presumptive eligibility determination.

~~Children who are determined presumptively eligible for Title XXI will receive the Title XIX benefit package until such time as eligibility for Title XXI is confirmed or denied. The State of Kansas provides Secretary Approved Coverage for Title XXI eligibles which includes The State Employee Health Plan as the benchmark coverage plus additional coverage that is medically necessary.~~

~~When formal determination of the PE application is complete, the child will be enrolled in the appropriate program, either Title XIX or Title XXI. Program placement will be based on established eligibility criteria.~~

Children who are determined presumptively eligible for Title XXI will receive the Title XXI benefit package until such time as eligibility for Title XXI is confirmed or denied. Presumptive Eligibility services are provided through a managed care model. These services are available statewide. When formal determination of the PE application is complete, the child will be enrolled in the appropriate program, either Title XIX or Title XXI. Program placement will be based on established eligibility criteria.

Children who are found presumptively eligible will receive the Title XIX benefit package. Title XIX offers services to persons eligible for Medicaid through a fee-for-service delivery system. These services are available statewide. Medically necessary services are obtained by beneficiaries through Medicaid contracting providers. Children may obtain care from any Medicaid contracting provider of their choice.

Claims for services being provided to individuals found to be presumptively eligible for CHIP will be processed in accordance with the State Medicaid Manual, Option 1 (report all expenditures at Medicaid match rate). For applicants who qualify at ~~201% - 241% of Federal Poverty Level,~~ or under 250% of the 2008 Federal Poverty Guidelines ~~they~~ must not have had any active health insurance for the time period of the application date minus eight months.

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

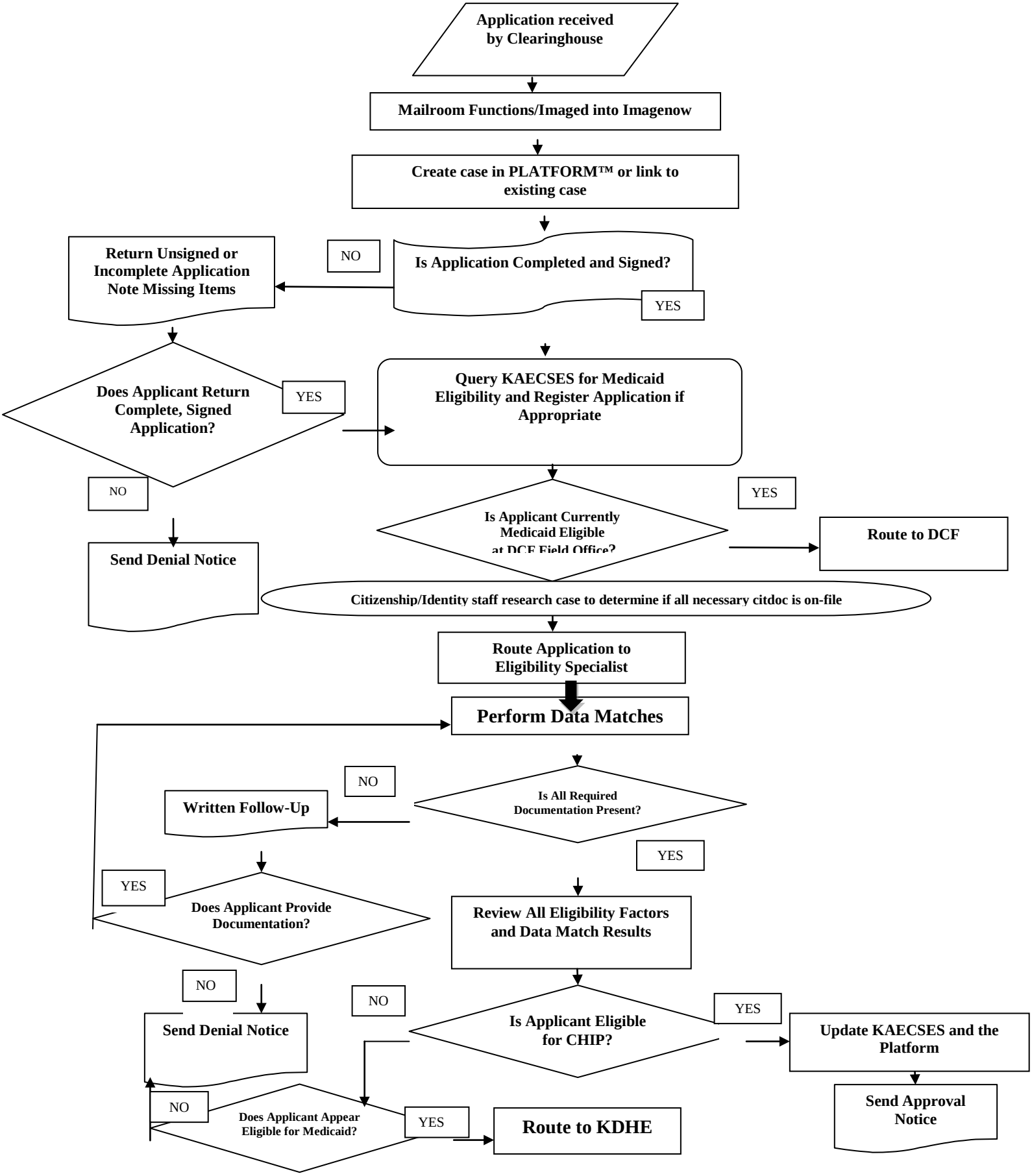
☒ Check here if this section does not apply to your state.

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 access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

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

Exhibit V-12
APPLICATION PROCESSING FLOWCHART



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))**

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

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

All applications are first reviewed for potential Medicaid eligibility, those found ineligible for Medicaid are immediately screened for CHIP eligibility. This process occurs at the same location, with the same workers, and no referral is required.

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 application/enrollment form is used to ascertain current health insurance coverage as well as access to state employee coverage. Children found to have current health coverage are denied eligibility for CHIP coverage.

In addition, access to state employee coverage results in denial of benefits under the CHIP program.

Premiums are charged to families above 150% of FPL in the CHIP program.

The central Clearinghouse application processing contractor monitors for substitution for coverage under group health plans through their application decisions software.

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.

This provision is not applicable to coverage dropped by a non-custodial parent (such as a stepparent or absent parent) or by a caretaker relative. It is also no applicable to coverage which was terminated for the following reasons:

- Loss of job from which health insurance was provided
- Death of a policy holder
- Termination of coverage by the policy holder's employer
- Termination of coverage due to financial hardship

Financial hardship exists when the monthly health insurance premium exceeds 10% of the household gross monthly income. Verification of the cost is required to establish a financial hardship exemption.

The application/enrollment form is used to ascertain current health insurance coverage as well as access to state employee coverage. Children found to have current health coverage or active health coverage from application date minus 8 months, are denied eligibility for CHIP coverage.

In addition, access to state employee coverage results in denial of benefits under the CHIP program.

Premiums are charged to families above 150% of FPL in the CHIP program.

The central Clearinghouse application processing contractor monitors for substitution for coverage under group health plans through their application decisions software.

Families will need to reapply after satisfactorily meeting the eight month waiting period.

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:

N/A

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))** The State has undertaken the following actions:

- Including ethnic information on the application for tracking Indian numbers.
- Including in the outreach media campaign and other outreach activities, the names of the community based organizations that serve Indian children, to assure that families are aware of the program and assist in the enrollment process.
- Using the three Indian Health Clinics as access points to provide enrollment materials and assistance to potentially eligible children.

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)**

~~Kansas uses methods to reach families when parents are receptive to the consideration of obtaining health insurance for their children. School-based events, such as Kindergarten Round-ups, school enrollments, and program flyers sent home during the winter flu season are methods used to communicate the availability of public health insurance. School nurses assist outreach efforts by informing families of this insurance option.~~

Kansas uses different methods to reach families when parents are interested in obtaining health insurance for their children. School based events such as enrollment, parent activities and outreach provided through school based nurses help increase enrollment opportunities. DHCF has 12 out stationed Eligibility Workers across the state, who partner with the school nurses, with local County Health Departments, and clinics serving low income Kansans. The Eligibility Workers attend health fairs, community based events and the Kansas State Fair manning tables and booths that provide information to potential beneficiaries, application assistance, and support to current beneficiaries. They act as local resources for KDHE CHIP beneficiaries and families.

With the start of KanCare, KDHE has conducted four rounds of statewide educational tours. Officials with KDHE and KDADS have made presentations on the KanCare program followed by a question and answer session for the public. More statewide tours are being scheduled. In addition to the tours, KDHE created a KanCare Website, which is used as a web based outreach tool and reference site for beneficiaries and providers. The KanCare Website has a section just for beneficiaries with a Frequently Asked Questions tab and educational materials on enrollment and the application process. Also new with KanCare is the Tribal Technical Advisory Group (TTAG). This committee is made up of KDHE employees and representative of the four Native American Tribes in Kansas. This group meets to address and facilitate discussion regarding Medicaid and healthcare reform issues involving both the state and the Tribes. KDHE uses this work group for Tribal feedback on KanCare issues and to provide information to the Tribal clinics.

Scheduled times at other public venues for families to complete an application are effective. Application assistance can take place in health departments during WIC pickup days, or at the state fair in September.

The business community is an effective partner in reaching parents. Many employers open their workforce and places of business to presentations and application assistance.

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 the Medicaid State Plan.

This coverage is available to all Title XIX and Presumptively Eligible CHIP children. Mental Health Services have parity with other covered services, and are covered at the Medicaid State Plan level.

See Section 6, Attachment A for coverage information regarding anti-hemophiliac medications and dental services.

Children who are found presumptively eligible will receive the Title XIX benefit package. Title XIX offers services to persons eligible for Medicaid through a fee-for-service delivery system. These services are available statewide. Medically necessary services are obtained by beneficiaries through Medicaid contracting providers. Children may obtain care from any Medicaid contracting provider of their choice.

Claims for services being provided to individuals found to be presumptively eligible for CHIP will be processed in accordance with the State Medicaid Manual, Option 1 (report all expenditures at Medicaid match rate). For applicants who qualify at ~~201% - 241% of the Federal Poverty Level,~~ or under 250% of the 2008 Federal Poverty Guidelines they must not have had any active health insurance for the time period of the application date minus eight months.

After final determination ~~of 12 months of continuous eligibility~~ is made for Title XXI eligibility, the State of Kansas provides Secretary Approved Coverage for Title XXI eligibles. ~~which~~This includes the State Employee Health Plan as the benchmark coverage plus additional coverage that is medically necessary.

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 (EPSDT)

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage.

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)**

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

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 6
Attachment A

OVERVIEW OF THE BENEFITS SCHEDULE
~~1999~~ Managed Care Benefits Schedule

The Kansas Children's Health Plan is ~~known~~ a~~s~~ ~~HealthWave.~~component of a comprehensive integrated plan known as KanCare.

Copayments and Deductibles

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

PHYSICAL HEALTH SERVICES

Physician Services

Physician services shall include: Diagnostic and treatment services by participating physicians and other participating health professionals; including office visits; periodic health assessments including school and camp physicals; hospital care; consultation; manipulation; surgical and non-surgical office procedures and injectable medications administered by the physician or medical staff under direction of the physician

Outpatient Services

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

Inpatient Hospital Services

Inpatient Hospital Services are provided upon prior approval of the Contractor, for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or on an outpatient basis. Hospital Services shall include semi-private room and board; care and services in an

intensive care unit; administered drugs, prescribed medications, biologicals, fluids and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; the administration of blood and blood products; x-rays, laboratory and other diagnostic services; anesthesia and oxygen services; inhalation therapy, radiation therapy; and such other services customarily provided in acute care hospitals.

Inpatient Services at Other Participating Health Care Facilities

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

Short-Term Rehabilitative Therapy

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

Home Health Services

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

Diagnostic Laboratory and Diagnostic and Therapeutic Radiology Services

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

Maternity Care

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

Family Planning Service Access and Confidentiality

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

~~**Services for Infertility**~~

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

Vision Services

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

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

Ambulance Service

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

Prescribed Drugs

A Participant is entitled to prescribed drugs as defined below. ~~Bidders~~MCOs must propose their Prior Authorization (PA) List. Future PA additions must be prior approved by ~~KHPA~~KDHE.

Plan Design:

Formulary: Open

Quantity/Days Supply: ~~34~~MCOs may determine, but the overall maximum may be no less than 31-day supply or less. ~~(one standard quantity)~~

Refills: ~~available after 75% of the original supply has been consumed~~MCOs have the option to set their own refill thresholds.

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

Maximum allowable quantity list: -- must be ~~included in the Vendor's Proposal~~submitted for State review.

EXCLUSIONS: Current fee-for service Medicaid exclusions are as follows, but MCOs have the option to cover these medications:

- Drugs for cosmetic purposes
- Drugs available without a prescription, except insulin, acetaminophen, ibuprofen, multivitamins, oral electrolyte solutions (such as Pedialyte), cough and cold preparations.
- Appetite suppressants, anorexiants or diet aids
- Experimental or investigational drugs
- Drugs not registered with the FDA or that do not have FDA approved indications

- Drugs furnished by local, state or federal government and any drug to the extent payment of benefits are provided or available from local, state or federal government whether or not that payment or benefit is received, except as otherwise provided by law.
- Replacement prescription drugs resulting from loss or theft.

Emergency Services

1. Definition of Emergency Services. Services which would be considered emergent by a prudent layperson must be covered under the Contract as required by the Federal Balanced Budget Act of 1997.

2. Emergency Services Within the Service Area. Emergency Services within the Service Area must be obtained from the Primary Care Physician or other Participating Providers. Participating Providers must be available on call twenty-four (24) hours a day, seven (7) days a week, to assist Participants needing Emergency Services. Emergency Services obtained other than as set forth above are covered only if the Contractor, on review, determines that the Participant had no control over where or by whom the Emergency Services were rendered.

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

4. Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, are covered unless authorized in advance by the Primary Care Physician or the Contractor.

Internal Prosthetic/Medical Appliances

Coverage for Internal Prosthetic/Medical Appliances authorized by the Primary Care Physician consists of permanent or temporary internal aids and supports for defective body parts. Repair or maintenance of a covered appliance is covered. Prosthetic devices are limited to the first surgically implanted device and the first ocular or prosthesis required as a result of accidental injury. The plan covers artificial limbs only to the extent of the first such artificial limb required. Special braces required to maintain the function of a disabled limb or required to support a functionally impaired body part. Penile implants only when required as a result of diabetes or other medical conditions. There is a maximum of one implant per lifetime which is a covered benefit unless the prosthetic

device or appliance is no longer suitable due to continued growth and/or development, providing the original prosthetic device or appliance was originally provided to a child.

Breast Reconstruction and Breast Prostheses

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

Durable Medical Equipment

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

Organ Transplant Services

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

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

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

Nutritional Evaluation

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

Hospice Services

Hospice Care Services when provided, due to Terminal Illness, under a Hospice Care Program is covered. Hospice Care Services shall include inpatient care; outpatient services; professional services

of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; bereavement counseling once every six weeks, and Home Health Services.

Effective with dates of service on and after March 23, 2010, individuals receiving services reimbursed by Medicaid and Children's Health Insurance Program (CHIP) can continue medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services.

Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children," allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or CHIP.

The Affordable Care Act does not change the criteria for receiving hospice services. However, prior to enactment of the new law, curative treatment of the terminal illness ended upon election of the hospice benefit. Hospice services are available to children ages 0-20 who are eligible for Medicaid and Medicaid-expansion CHIP programs without termination of any other service which the child is entitled to under Medicaid for treatment of the terminal condition.

Hospice Care Services do not include the following:

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

Oral Surgery Benefits

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

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

~~**Anti-hemophiliac factors:** Providers are directly reimbursed on a Fee-For-Service basis with prior approval of KHPA KDHE .~~

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

The State of Kansas deemed our CHIP children as state eligible children for immunizations. ~~The Kansas Health Policy Authority entered into an agreement with t~~The Kansas Department of Health and Environment ~~to buy~~purchases vaccines for children off of ~~their~~ a federal contract. Providers in the CHIP program have their vaccines provided to them off of this contract.

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

Vaccines included in the CDC Recommended Childhood Immunization Schedule

Kansas adjusts to meet the CDC immunization schedule when changes are made.

The following vaccines if indicated:
Hepatitis A (Hep A)
Influenza Virus (Flu)
Pneumococcal (Pneumo)

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

Inpatient and Outpatient Behavioral Health Services

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

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

Substance Abuse Services

Inpatient:

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

The benefits may be exchangeable with partial hospitalization sessions, if medically necessary and appropriate, of not less than three (3) hours and not more then twelve (12) hours in any twenty-four (24) hour period, based upon the following exchange formula: If the charge for one partial hospitalization session does not exceed fifty (50) percent of the allowable charges for one inpatient

day of the average semi-private rate at the Participating Hospital where the session is conducted, the benefit exchange shall be two (2) partial hospitalization sessions equal to one day of inpatient care. If the charge for one partial hospitalization session does not exceed fifty (50) percent of the allowable charges for one inpatient day for the average semi-private rate at the Participating Hospital where the session is conducted, the benefit exchange is one partial hospitalization session equal to one day of inpatient care.

Outpatient:

The following explanation and limitations apply to all rehabilitation services, which are the following:

- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation
- Peer Support
- Crisis Intervention
- Outpatient Substance ~~Abuse Services~~ Use Disorders

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all CHIP eligibles with significant functional impairments resulting from an identified mental health diagnosis or substance abuse diagnosis. The medical necessity for these rehabilitative service must be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law, and furnished by or under the direction of a physician, to promote the maximum reduction of symptoms and/or restoration of a recipient to his/her best possible functional level.

Limitations:
Services are subject to prior approval, must be medically necessary, must be recommended by a licensed mental health practitioner or physician according to an individualized treatment plan, and must be furnished under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. Anyone providing substance abuse treatment services must be licensed under K.S.A. 65-4601, in addition to their scope of practice license.

Medical necessity of the services is determined by a licensed mental health practitioner or physician conducting an assessment consistent with state law, regulation and policy.

Services provided at a work site must not be job tasks oriented. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institute for mental disease (IMD).

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.
Definitions:

The services are defined as follows:

1. Community Psychiatric Support and Treatment (CPST) are goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the consumer's individualized treatment plan. CPST is a face-to-face intervention with the consumer present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the person lives, works, attends school, and/or socializes.

This service may include the following components:

A. Assist the consumer and family members or other collaterals to identify strategies or treatment options associated with the consumer's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the consumer's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.

B. Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the consumer, with the goal of assisting the consumer with developing and implementing social, interpersonal, self care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.

C. Participation in and utilization of strengths based planning and treatments which include assisting the consumer and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.

D. Assist the consumer with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the consumer and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

Provider qualifications: Must have a BA/BS degree or four years of equivalent education and/or experience working in the human services field. Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a standardized basic training program.

2. Psychosocial Rehabilitation (PSR) services are designed to assist the consumer with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve identified goals or objectives as set forth in the consumer's individualized treatment plan. The intent of psychosocial rehabilitation is to restore the fullest possible integration of the consumer as an active and productive

member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the consumer present. Services may be provided individually or in a group setting. The majority of PSR contacts must occur in community locations where the person lives, works, attends school, and/or socializes.

This service may include the following components:

A. Restoration and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and effective functioning in the consumer's social environment including home, work and school.

B. Restoration and support with the development of daily living skills to improve self management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the consumer with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.

C. Implementing learned skills so the person can remain in a natural community location.

D. Assisting the consumer with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider qualifications: Must be at least 18 years old, and have an high school diploma or equivalent. Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a standardized basic training program.

3. Peer Support (PS) services are consumer centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the consumer's individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for consumers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. PS is a face-to-face intervention with the consumer present. Services can be provided individually or in a group setting. The majority of PS contacts must occur in community locations where the person lives, works, attends school, and/or socializes. This service may include the following components:

A. Helping the consumer to develop a network for information and support from others who have been through similar experiences.

B. Assisting the consumers with regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnoses or treating with their treating clinician.

C. Assisting the consumer with the identifying and effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider qualifications: Must be at least 18 years old, and have a high school diploma or equivalent. Certification in the State of Kansas to provide the service, which includes

criminal, abuse/neglect registry and professional background checks, and completion of a standardized basic training program. Self identify as a present or former consumer of mental health services.

4. Crisis Intervention (CI) services are provided to a person who is experiencing a psychiatric crisis, designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of Crisis Interventions are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. Crisis intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school, and/or socializes. This service may include the following components:

A. A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.

B. Short-term crisis interventions including crisis resolution and de-briefing and follow-up with the individual, and as necessary, with the individual's caretaker and/or family members.

C. Consultation with a physician or with other providers to assist with the individual's specific crisis.

Provider qualifications: Must be at least 18 years old, and have an AA/AS degree or two years of equivalent education and/or experience working in the human services field. Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a standardized basic training program.

5. Outpatient substance abuse services include an array of consumer centered outpatient and intensive outpatient services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. These services are delivered in a wide variety of settings and are nonresidential services designed to help individuals achieve changes in their substance abuse behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to undermine the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment, or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services.

Provider qualifications: Must be licensed under K.S.A. 65-4601.

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

Section 6
Attachment A

DENTAL SERVICES

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

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

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

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

Full mouth x-rays once every five years.

Preventive: Provides for the following:

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

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

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

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

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

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

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

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

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

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

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

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

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
Tools to assure quality will include:

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

7.1.2. ☒ Performance measurement
Tools to measure performance will include:

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

7.1.3. ☒ Information strategies
Tools to measure information strategies will include:

- Review of enrollment materials
- Survey results
- Grievance results

7.1.4. ☒ Quality improvement strategies
Tools to monitor quality improvement strategies will include:

- Corrective action plans
- Compliance audits

- Review of utilization rates
- Review and approval of quality studies

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))**

The state assures access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations by monitoring reports received by the fiscal agent through the analysis of encounter data.

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

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

Goals underlying the implementation of this quality care are:

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

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

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

EXTERNAL MONITORING

External Quality Review Organization (EQRO)

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

INTERNAL MONITORING

Contract Compliance Review

Each of the contracts between ~~KHPA~~ KDHE and participating MCO plans contain specific performance objectives. ~~KHPA~~ KDHE monitors contracting ~~HMOs~~MCOs, on a periodic basis, to determine compliance with these performance objectives. Areas to be monitored include, but are not limited to:

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

Grievance Review

A grievance is defined as an expression of dissatisfaction about any matter including a denial of or limited authorization of requested service(s).

A grievance requires formal written documentation. A thorough investigation is made and appropriate resolution presented to the consumer. All calls and letters from members are received in the customer service unit. Every inquiry (calls or letters) are logged. Once the inquiry is logged, it is evaluated to determine if the inquiry should be handled by professional medical staff.

Professional medical staff receives grievances regarding utilization, quality of care, and access. Each inquiry is researched thoroughly and responded to. Clinical education is given to members by this staff.

At any time a consumer may request a fair hearing from the state in conjunction with a grievance.

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))**

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

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

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))**

Contracts with the MCOs require the following:

- Access Standards which is inclusive of specialty networks;
- Assignment of beneficiaries; and
- Referral Standards

The Title V Director sends medical care plans for children with special health care (Title V) needs to the MCO. The MCO Medical Director and the Title V Director send a letter to the child's primary care provider that includes the child's medical

care plan asking the primary care provider's cooperation in providing the necessary referrals for the child to continue to receive services from current specialists.

~~The provider network is sent electronically to the EQRO who, in turn, monitors access through GEO mapping. If gaps are noted, recruitment efforts are initiated on the part of the MCO and an exception mapping occurs in six (6) months.~~
The provider network is sent electronically to the State. This submission includes a comprehensive list of all statewide network providers, as well as an access report. The access report includes Geo Access mapping by provider specialty and is reviewed by State staff to ensure the provider network meets contract and access standards.

Beneficiaries are automatically assigned to a primary care provider in the MCO in order to assure immediate access to care. The beneficiary may choose to change providers after enrollment by notifying the MCO. This is monitored through complaints and grievances.

These issues are monitored through the EQRO by their annual audit of the MCO. In the annual audit the EQRO obtains a list of all denied claims. From this list a sample is taken and the areas that are reviewed are: timeliness of filing, referral standards, provider's in or out-of-network, and appropriateness of denial. The findings are reported to the State, the State then works with the MCO to address any issues that arise.

7.2.4 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))**

The contracts with the MCOs require that decisions regarding all covered services be made no longer than 48 hours after the request.

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: $20 per month per family where family income is between 151% and 175% of FPL
$30 per month per family where family income is between 176% and 200% of FPL
$50 per month per family where family income is between 201% and 225% of FPL
~~$75 per month per family where family income is between 226% and 241% of FPL~~

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments: None

8.2.4. Other: None

8.3. Describe how the public is 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))**

Information regarding premiums is provided with the application and upon eligibility determination and redetermination if the family is in premium paying status. The ~~HealthWave~~ KanCare website ~~(www.kansashealthwave.org),~~ (http://www.kdheks.gov/hcf/medical_assistance/apply_for_assistance.html), brochure, provider's offices, all have premium 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 ensures 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))**

Premium limits were established to insure that the aggregate cost-sharing for a family did not exceed 5% of the family's annual income. Families have the option of paying monthly, quarterly, or on any other basis convenient to the family. The only requirement is that the full amount of the premium requirement be paid before renewal.

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

An ethnicity designator is collected at the time of application. This is a self-declaration field on the application. If the indicator for a family is marked American Indian or Alaskan Native and they are eligible for Title XXI, no premium is charged.

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))**

An enrollee family has a full year to meet their premium obligation. Notices are sent monthly outlining the amounts due, or paid. At 45 days before the end of the eligibility period, a final notice is sent informing the enrollee that if the premium is not paid in full coverage ends. An enrollee must pay all delinquent premiums, or provide information that they are no longer in a premium paying status, before eligibility is redetermined.

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 facilitates 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 are 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) is used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** *(Previously 8.4.5)*

8.8.3. ☒ No funds under this title are 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 includes 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 are 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))**

1. Reduce the number of uninsured non-Medicaid eligible children under 19 years of age and ~~below 241% FPL~~ under 250% of the 2008 Federal Poverty Guidelines in the State of Kansas.
2. Assure that the enrolled children with significant health needs have access to appropriate care.
3. Assure that the enrolled children receive high quality health care services.
4. Increase the percentage of enrolled children with regular preventive care.

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

~~**Strategic Objective #1**~~

~~Performance Goal: To reduce the number of children eligible for HealthWave KanCare XXI coverage within the State of Kansas without insurance to less than 5% of the total number of children of all income levels.~~

~~Performance Measure: We are measuring what percentage of the total number of children below 19 years of age and eligible for Medicaid or CHIP are uninsured.~~

Strategic Objective #~~2~~1

Performance Goal: Enrollment in ~~HealthWave~~ KanCare XXI continues to increase by ~~a rate of~~ 3% annually.~~as indicated by an increase of coverage of children eligible for CHIP~~

Performance Measure: This percentage will be measured by subtracting the sum of the previous years' eligible members (PY elig) from the current year's number of eligible members (CY elig), and dividing the sum by the previous years' final eligible members. (CY elig – PY elig)/PY elig).

~~Performance Measure: The number of children who qualify for medical benefits in the State of Kansas is constantly changing. With our ability to educate the public and potential members, Kansas has reached a capacity and is no longer to meet the numerical expectations of a new plan when it comes to growth. Kansas will take a new approach to reach and increase enrollment based on achieving enrollment of a percentage of~~

the potential members.

This will be measured by subtracting the sum of the previous year's final number of eligible members (PY elig) from the current year's final number of eligible members (CY elig) and then dividing the sum by the previous year's final number of eligible members ((CY elig. – PY elig.)/PY elig.).

Strategic Objective #32

Performance Goal: Annually, a minimum of 80% of children enrolled in CHIP report overall satisfaction with their health plan.
To increase the rate of children enrolled in Medicaid and CHIP who receive any preventive dental service by 10 percentage points over a 5 year period.

Performance Measure: The Consumer Assessment of Health Plan Study (CAHPS) survey will reflect that 80% of the surveyed children/families express satisfaction with the health plan.
EPSDT data reported monthly by the MCOs will be monitored quarterly by DHCF through the CMS 416 reporting process.

Strategic Objective #43

Performance Goal: Eighty percent of enrolled children receive one or more Early and Periodic Screening Diagnostic and Treatment (EPSDT) services.
Annually a minimum of 80% of children enrolled in CHIP report overall satisfaction with their health plan.

Performance Measure: The State's contracts require reporting quarterly to KHPA KDHE through the CMS 416 format over a rolling 12 month period. KHPA KDHE will review these quarterly reports to assess compliance, and discuss MCOs improvements where necessary.
The Consumer Assessment of Health Plan Study (CAHPS) 5.O with Children with Chronic Conditions (CCC) survey will reflect that 80% of surveyed children/families will express satisfaction with the health plan.

Strategic Objective #4

Performance Goal: Eighty percent of enrolled children receive one or more Early and Periodic Screening Diagnostic and Treatment (EPSDT) services.

Performance Measure: EPSDT data reported monthly by the MCOs will be monitored quarterly by DHCF through the CMS 416 reporting process.

Performance Improvement Projects

As part of the comprehensive KanCare managed care program, each of the MCOs is required to conduct at least two Performance Improvement Projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The MCOs must submit new data on at least two (2) PIPs annually to the State. The subject matters of the PIPs are developed collaboratively between the MCOs and the State, and evolve over time, based upon the results of the PIP interventions and other clinical/non-clinical factors and priorities. In addition, the KanCare program has a robust array of performance measures, including substantial pay for performance measures, the results of which will inform the selection of PIP focus areas over time. Initially, the MCOs will be – either collectively or individually – conducting PIPs that relate to these issues:

- Comprehensive diabetes care
- Increasing the percentage of members ages 3-6 who have an annual well child examination

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))**

The State contracts with an External Quality Review Organization (EQRO) to verify performance goals and identify needed areas of improvement.

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)**

The State of Kansas currently follows, and plans to continue to follow, the template for the annual report provided by NASHP.

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 conception of the CHIP program in Kansas occurred through multiple stakeholder meetings during 1997 and 1998. These meetings included members of the Kansas Legislature, Kansas Insurance Department, Kansas Medical Society, The Kansas Department of Health and Environment, local pediatricians and pharmacists, physical health providers, health care professional associations, SRS employees and advocacy groups. Their input was used in the design of Senate Bill 424, which authorized the CHIP plan for the State of Kansas.

The Medicaid Director chairs a committee, Medical Care Advisory Council (MCAC) which represents beneficiaries and various health care professionals. The purpose is to provide input into the current processes of the CHIP program. Community advocates and provider boards are both utilized when appropriate and unhindered by HIPAA regulations.

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))**

~~Kansas Health Policy Authority~~Kansas Department of Health and Environment will establish and maintain periodic meetings to consult and obtain feedback specifically with the Indian Tribe Medical Directors and/or designees, prior to implementation of any plan amendments, waiver requests, and proposal for demonstration projects likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. A process for written notice and feedback from Tribal leaders regarding changes in the CHIP program is in place.

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)

Prior public notice was published in the Kansas Register on December 19, 2002, in relationship to CHIP State Plan Amendment #4 which increases premiums for HealthWave.

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

Actual and Projected Budget for Kansas CHIP Program - as of April 2013

	Federal Fiscal Year 2012 total costs	Federal Fiscal Year 2013 premium change, PPS payments	Change between 2012 to 2013
Benefit Costs			
Insurance payments			
Managed care	57,621,920	66,365,000	8,743,080
per member/per month rate X # of member months	103.34 X 557,604	110.45 X 600,792	7.11 PMPM
* Fee for Service (FFS)	14,469,680	3,000,000	(11,469,680)
FFS increase for RHC and FQHC wrap payments and cost settlements	0.00	0.00	0.00
Total Benefit Costs	72,091,600	69,365,000	(2,726,600)
(Offsetting beneficiary cost sharing payments)	(2,489,890)	(2,500,000)	(10,110)
Net Benefit Costs	69,601,710	66,865,000	(2,736,710)
Administration Costs			
Personnel	285,900	285,000	(900)
General administration	141,200	141,000	(200)
Contractors/Brokers (e.g., enrollment contractors)	3,668,000	3,148,900	(519,100)
Claims Processing	2,563,700	2,400,000	(163,700)
Outreach/marketing costs	0.00	0.00	0.00
Other	62,000	62,000	0.00
Total Administration Costs	6,720,800	6,036,900	(683,900)
10% Administrative Cost Ceiling	7,733,523	7,429,444	(304,079)
Federal Share (multiplied by enhanced FMAP rate)	53,303,641	50,710,562	(2,593,079)
State Share	23,018,869	22,191,338	(827,531)
TOTAL PROGRAM COSTS	76,322,510	72,901,900	(3,420,610)
Enhanced FMAP eff. 10-1-2011	0.6984	0.6956	(0.0028)

*Note: Contractor includes payment for applications, processing, enrollment, marketing, and fiscal agent functions.

- ☐ 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.

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 state contracts with a private entity to manage, determine and redetermine eligibility and to collect premium fees. The State of Kansas follows the Kansas Medicaid Fair Hearing and Appeal process for CHIP.

Health Services Matters

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

The state contracts with an External Quality Review Organization (EQRO) to perform an annual audit of the Title 21 Service Delivery Program. The State of Kansas follows the Kansas Medicaid Fair Hearing and Appeal process for CHIP.

Premium Assistance Programs

12.3. 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.

N/A