

**Testimony on:**  
State Children's Health Insurance Program

**presented to:**  
Joint Committee on Children's Issues

**by:**  
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**October 30, 2007**

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Joint Committee on Children's Issues  
October 30, 2007

**State Children's Health Insurance Program Update**

Good morning Madame Chair. I am Andrew Allison, Deputy Director of the Kansas Health Policy Authority (KHPA). I would like to thank you for the opportunity to provide an update on the HealthWave program, focusing on the State Children's Health Insurance Program (SCHIP) population as requested each year by this committee. Also with me today are the contracting vendors whom you will hear from in a few moments.

**Background**

SCHIP, authorized in Title XXI of the Social Security Act, expands coverage to children whose families are not income eligible for Title XIX Medicaid, but who often lack access to affordable private coverage. In Kansas, HealthWave XXI is available statewide to children who are Kansas residents, are from birth to 19, and who live in families with incomes up to 200% of the Federal Poverty Level (FPL) or approximately \$33,200 per year for a family of three. Eligible children receive 12 months of continuous coverage

Kansas' SCHIP program was implemented under the program name HealthWave in January of 1999. In 2002, the SCHIP program was integrated with the Medicaid capitated managed care program to create seamless coverage for the blended families all encompassed under the HealthWave program name (approximately ¼ of covered families have children in both Medicaid and SCHIP). The current income thresholds for the combined HealthWave program are shown in Attachment 1, which indicates the stair step eligibility between Title XIX Medicaid and Title XXI SCHIP. As of June 2007, 35,374 Kansas children were enrolled in HealthWave XXI, with total service expenditures in FY 07 \$59.5 million. Also in June 2007, there were 115,286 members (98,176 children and 17,110 adults) in HealthWave XIX with a total expenditure of \$282.1 million.

The federal funding for HealthWave XXI is based on a capped annual grant. The federal law authorizing SCHIP on a 10 year appropriation ended September 30, 2007. This law allowed Kansas to carry over unspent funds past this date. At this point KHPA estimates approximately \$8 million in carry over funds. On September 29, 2007, Congress passed HJR52, a continuing resolution that appropriated \$5 billion dollars nationally to cover SCHIP expenditures for part of the 2008 federal fiscal year. These funds are available only after exhausting carry over dollars, and only through November 15, 2007. We expect to rely solely on previously unspent carryover funds during this period, and will not need any of the \$5 billion appropriation. We are monitoring the national discussion over the reauthorization of the SCHIP program closely, and have been encouraged by legislative initiatives to establish a rational and empirically-driven approach to enforce citizenship and identification requirements, and to fund Kansas' program fully on an ongoing basis. We continue to advocate for Federal funding that is sufficient to enroll all eligible children, that fairly allocates funds across states regardless of their historical decisions to extend coverage to children and families, and that extends flexibility to states in the manner in which these funds are used to provide and protect access to health care services for the target population.

**Update on SCHIP**

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## **Service Provision and Managed Care Organizations**

The state currently contracts with two managed care organizations (MCOs), UniCare Health Plan of Kansas and Children's Mercy Family Health Partners, to provide physical health benefits for HealthWave XIX and HealthWave XXI members. Kansas has been divided into 3 service regions. Regions 1 and 2 are covered by both companies while Region 3 has only UniCare Health Plan of Kansas (see Attachment 2). KHPA also contracts with Cenpatico Behavioral Health to provide mental health coverage to HealthWave XXI members, while providing dental coverage in a fee for service model.

Last year, KHPA reported partnering with UniCare Health Plan of Kansas and Children's Mercy Family Health Partners effective January 1, 2007. This year, we are excited to report the successful transition from one MCO to multiple MCOs. There were very few interruptions in medical coverage for the members, and both companies have exerted significant effort to build and continue to expand their provider networks. Early issues with timely payment in our plans have been addressed now UniCare averages two days receipt to pay while CMFHP averages 22 days receipt to pay. Both plans continue to build provider networks. Tools they bring to bear in recruitment include professional contacts, negotiated payments, and corporate reputation and administrative proficiency. One of the key motivations for the state in contracting with private health plans is the freedom they have to provide creative value added services to our beneficiaries, such as care management for those with costly medical conditions. UniCare Health Plan and Children's Mercy Family Health Partners are offering care management programs for groups such as high-risk pregnant mothers, asthma, diabetes and obesity. These programs focus not only on taking care of the member and providing necessary services, but also on teaching healthy lifestyles.

KHPA, through the HealthWave program, is committed to providing quality services to Medicaid and SCHIP beneficiaries. This "Quality" is assessed and assured through a number of different avenues. To monitor plan performance, KHPA relies on both administrative health records and beneficiary survey results submitted on a routine basis by each plan. HEDIS (Healthcare Effectiveness Data and Information Set) data is an effective measurement of overall participation in well care visits and assessing benchmarks for standards of care. The MCOs also field a CAHPS survey (Consumer Assessment of Healthcare Providers and Systems), that is used to assess the satisfaction of the membership with the overall plan performance, network, specialty care they receive, and customer service. KHPA has contracted with the Kansas Foundation for Medical Care (KFMC) to act as the External Quality Review Organization (EQRO) of the quality program. The EQRO reviews all aspects of an MCO's quality program to ensure data integrity, reliability of the information, and how transferable the information is across the plan. In particular, they review all HEDIS measures and CAHPS surveys to ensure appropriate protocols have been followed, enabling comparability of results to other MCOs and/or state SCHIP programs.

KHPA assesses the performance of the MCO's through other means as well. For example, the MCOs submit weekly claims reports allowing KHPA to monitor claims payment, the level of denial, as well as the number of claims in suspense. Grievance logs are provided and reviewed quarterly to identify possible areas for improvement within each MCOs organization. UniCare Health Plan of Kansas and Children's Mercy Family Health Partners also submit their respective provider networks monthly to allow KHPA to assess network capacity. KHPA can report there are a combined 2,433 unique providers acting as "Primary Care Providers" in 2,732 locations across Kansas. To augment these reports, KHPA has routine contact with provider associations such as the Kansas Medical Society and the Kansas Hospital Association and quarterly meetings with providers to hear concerns first hand, even before a problem becomes evident in the routine data that is submitted.

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## **Eligibility Clearinghouse and the Challenges of the Federal Citizenship Requirement**

A year has passed since the new federal citizenship requirements went into effect on July 1, 2006. They require that all Medicaid applicants provide adequate documentation of citizenship and identification.

The requirement of additional documentation for each and every applicant significantly altered the normal processes to apply for medical benefits. Each person applying for benefits is now required to submit either one primary document verifying citizenship and identity such as a passport or certificate of naturalization, or two secondary documents, one verifying citizenship, such as a birth certificate and one verifying identity, such as a drivers license or school id card. For example, in the past, an applicant with two children would submit an application on their own behalf and on behalf of their two children, and the necessary income verification documentation. Under the new rules, the same family now submits all of the same documents plus they need to submit an additional six documents -- two citizenship/identity documents per person.

At the beginning the applicants were confused by what it was they were being asked to verify and what documents they needed to provide. As a result, more cases were pended because of missing documentation, and in turn, this generated more customer service phone calls and significantly strained many other processes and systems. The sheer volume of physical documents that are routinely received by the Clearinghouse has more than doubled since the implementation of this requirement. Each of these documents must be verified, processed and stored for future reference. As a result, the average amount of time it takes to complete the processing of a family's application has increased.

The first year of this requirement has been the most difficult, because each month this past year the Clearinghouse has been conducting verifications for not only the average 3,500 monthly new applicants, but also for the average 5,000 current beneficiaries who are scheduled for their annual eligibility review. After the verification was performed for all current beneficiaries, the information has been kept on file for future access at the next review time and the requirements now only affect new applicants.

This new mandate impacted beneficiaries in many way resulting in an original drop in caseload of about 20,000 people between June 2006 and October 2006. Many of those who lost coverage eventually regained coverage once they gathered and provided the necessary documentation. They, however, experienced a gap in coverage that we know proved to be significant for some.

KHPA put in place measures to deal with some of these issues. We reallocated some resources within our existing contract with MAXIMUS, who you will hear from this morning. However, reallocation was not sufficient to remedy the situation. As a result, KHPA made a supplemental request to add nine additional staff to the Clearinghouse for FY 2007. The request was approved by the legislature. The additional funds allocated to KHPA by the legislature were used to add 13 contract staff and 4 state staff. All staff was on board by the first week of July 2007. We are continuing to reallocate resources as needed and we are continuing to use overtime to supplement the newly allocated funds. Since the additional of the new resources, KHPA has made significant progress in reducing the number of unprocessed applications and reviews. Beginning of February 2007 we had reached a peak of 15,000 applications and reviews which were received and remained unprocessed. Of those, the total number of applications which were over 25 days old was 4,729 and the total number of reviews which were over 25 days old was 3,280.

For the months of Feb thru October 11, 2007 we received an additional 34,970 applications and 43,412 reviews to process for an impressive total of 78,382 requests for medical assistance. In spite of the large number of additional requests, as of 10/11 the total number of unprocessed applications and reviews has been reduced to 5,920. The total number of applications over 25 days old has dropped to 524 and the total number of reviews

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over 25 days old has dropped to 39.

	Unprocessed applications and reviews in house	Applications over 25 days old	Reviews over 25 days old
Feb 2007	15,000	4,729	3,280
Sept 26, 2007	6,399	982	887
Oct 11, 2007	5,920	524	39

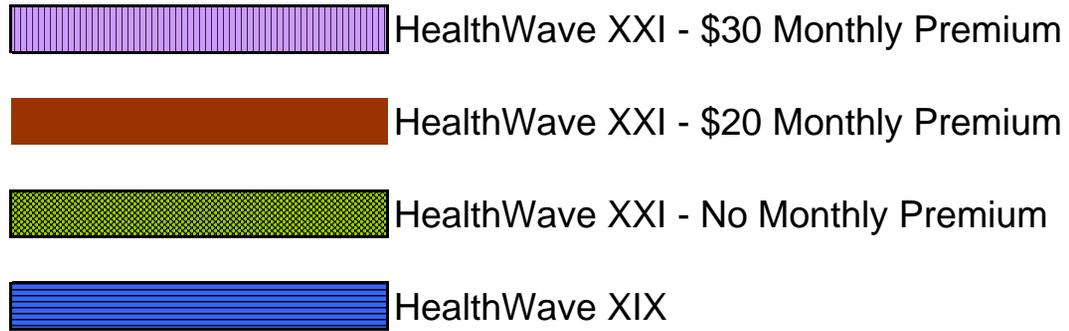
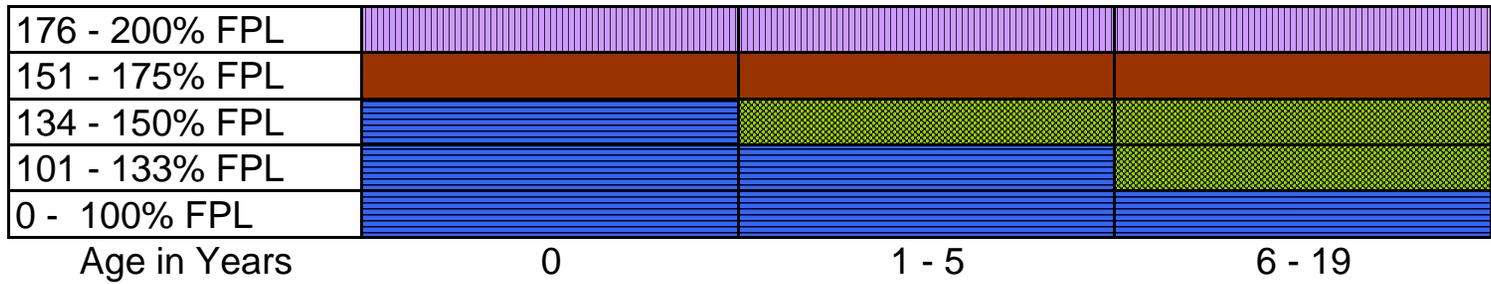
We are on target to reach our goal of having applications and reviews fully processed within 25 days of receipt by January 2008.

### **Conclusion**

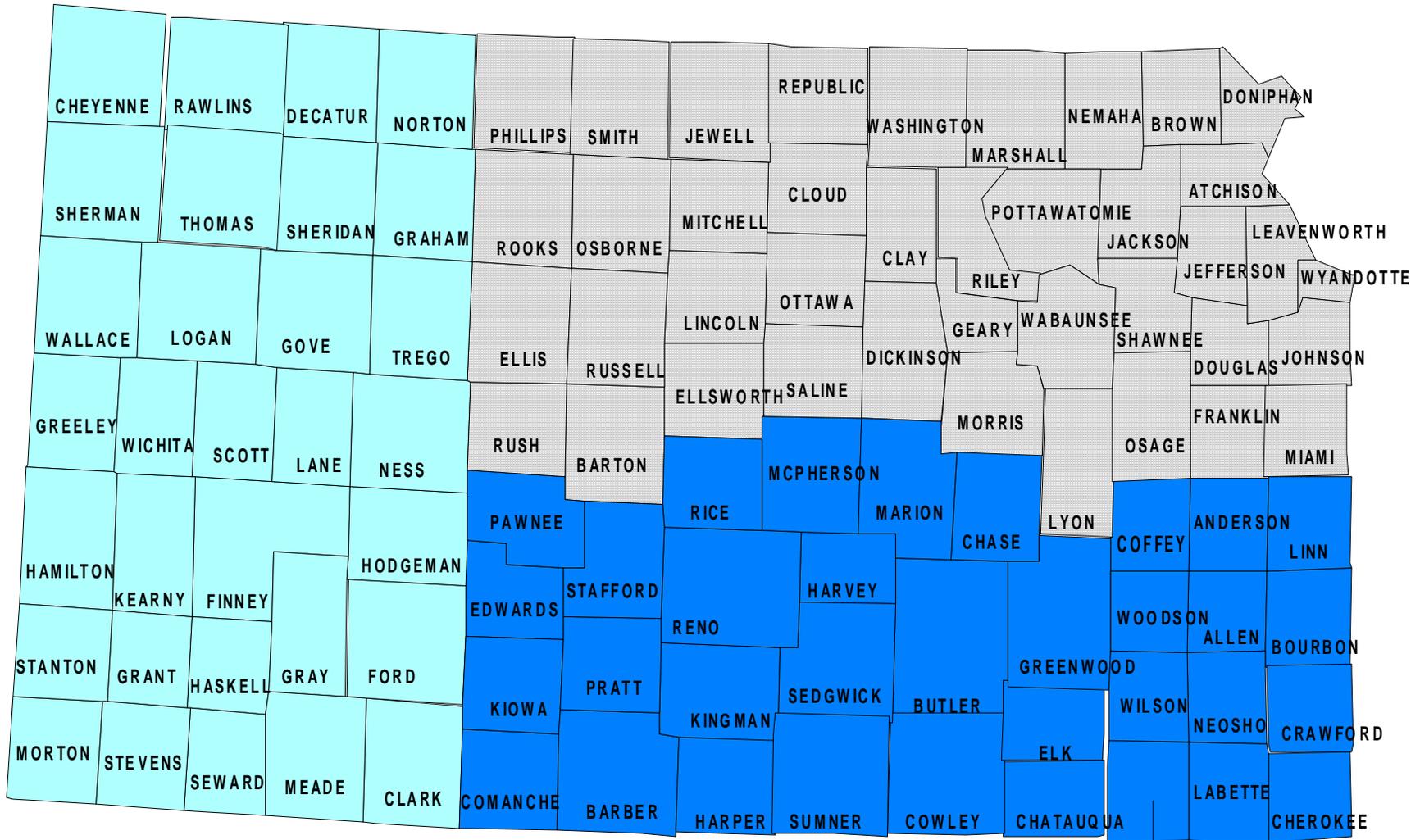
KHPA is cautiously optimistic as we look to the future of SCHIP in Kansas. We anxiously await a plan to reauthorize SCHIP and are hopeful the authorization will allow KHPA to continue to strengthen the HealthWave program, reaching out to all eligible and uninsured children and families enrolling them. While we wait for the Federal government to clarify SCHIP's future, we are actively building on the strong programmatic base that the HealthWave program has provided here in Kansas. The health reform proposals the KHPA will bring to the Legislature and Governor on Thursday will focus on expanded use of private health plans to meet the needs of the uninsured through the premium assistance program, which will take privatization to the next stage by offering benefits on a par with levels our consumers can expect to find in the private sector. Reforms will also emphasize private sector innovation and effective outreach and enrollment, building on the progress made when the HealthWave program was introduced in 1999, and a new approach for coverage of family units that more effectively transitions them off of publicly-financed coverage. We look forward to working with the Legislature to consider these proposals, even as we work to strengthen the programs that we have in place.

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# Managed Care Service Regions



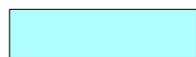
MONTGOMERY



Region 1 Children's Mercy Family Health Partners & UniCare Health Plan of Kansas, Inc.



Region 2 Children's Mercy Family Health Partners & UniCare Health Plan of Kansas, Inc.



Region 3 UniCare Health Plan of Kansas, Inc.