Kid Care CHIP:

Wyoming's State Children's Health Insurance Program

Management Audit Committee
June 2007

Management Audit Committee

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EXECUTIVE SUMMARY

Kid Care CHIP: Wyoming's State Children's Health Insurance Program

Program Evaluation Section **June 2007**

Purpose

In December 2006, the Management Audit Committee directed staff to undertake a review of Wyoming's State Children's Health Insurance Program (SCHIP), known as Kid Care CHIP. The program pays for health insurance coverage for low-income children whose family incomes are too high for Medicaid, but below 200 percent of the FPL (federal poverty level). In 2007, the FPL is about $40,000 for a family of four.

Background

In 1997, Congress created SCHIP to provide capped funding for states to expand low-income children's access to health care. Congress gave states flexibility in designing their programs, and latitude in establishing eligibility and benefits levels. The Wyoming Legislature created Kid Care CHIP in 1999, and extensively revised the program in 2003. Currently the federal government funds approximately two-thirds of the costs of Kid Care CHIP.

This study comes at an important time for the program, with Congress considering SCHIP reauthorization and with that, changes to the overall funding amount and distribution method. Should Congress decide to reduce or eliminate funding for SCHIP, Wyoming's Legislature will face the decision of whether to increase state appropriations to keep the program intact.

Results in Brief

In its brief history, Kid Care CHIP has increased the number of Wyoming low-income children with access to health care. As of February 1, 2007, almost 5,500 children participated in Kid Care CHIP, and another 31,000 low-income children had access to medical benefits through EqualityCare (Wyoming's Medicaid).

Achieving a reduction in the number of uninsured low-income children has occurred in part because the Legislature has expanded coverage for children several times. Before 1999, public health insurance was available only for children in families with incomes up to 100 or 133 percent FPL, depending on the child's age. Since then, the Legislature has expanded eligibility for Kid Care CHIP and now, children up to 200 percent FPL can receive health care coverage through one of the two programs, Kid Care CHIP or EqualityCare, depending on family income.

Kid Care CHIP's federally-mandated outreach efforts have also contributed to this success. Wyoming has benefited from two Robert Wood Johnson Foundation grants totaling almost $1.6 million to fund outreach, improve coordination between children's public health insurance programs, and other purposes. Enrollment in both Kid Care CHIP and EqualityCare has grown: for example, twice as many children are now in EqualityCare as in 1999.

National studies have found that uninsured children are less likely than those with insurance to receive preventive care or treatment for injuries and chronic illnesses. We found that most Kid Care CHIP enrollees *are* using health care services: during one year, over 80 percent of enrolled children used at least one health care service. Overall, we conclude that Kid Care CHIP has been effective in reducing the number of uninsured children in the state, is working as intended, and is taking steps to refine and improve its operations.

Principal Findings

Kid Care CHIP is responding to problems and looking for solutions. We focused on two areas of program weakness and how program managers have responded to them. First, some children are enrolled in both Kid Care CHIP and EqualityCare, which results in unnecessary expenditures for the state and federal government. Second, many children enrolled in Kid Care CHIP are not using the well-child visits that could help make them healthier. Program managers have developed strategies for addressing both of these issues.

Kid Care CHIP can improve use of administrative data to help focus efforts and target expenditures. The program gathers a considerable amount of data on enrollees, eligibility decisions, and use of health care services, but much of this information is not accessible to its managers because of how its data system is structured.

Kid Care CHIP has been successful in keeping administrative spending low so that most expenditures go directly to children's health expenses. However, we believe the cost of obtaining greater access to the data will be more than offset by an enhanced ability to analyze and problem-solve. This will better position Kid Care CHIP to respond to future program and policy changes, such as those that may come with federal reauthorization of SCHIP.

Agency Comments

The Department of Health partially agrees with the recommendation that Kid Care CHIP should continue to look for ways to improve. WDH also partially agrees with the recommendation that the program develop better access to existing administrative data. The agency believes it is already doing these things and says program staff is working to create some of the suggested reports.

Copies of the full report are available from the Wyoming Legislative Service Office. If you would like to receive the full report, please phone 307-777-7881. The report is also available on the Wyoming Legislature's website at legisweb.state.wy.us

Recommendation Locator

Finding Number	Page Number	Recommendation Summary	Party Addressed	Agency Response
1	16	Kid Care CHIP should continue to look for ways to improve.	Kid Care CHIP	Partially Agrees
2	23	Kid Care CHIP should develop better access to existing administrative data.	Kid Care CHIP	Partially Agrees

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INTRODUCTION

Scope and Acknowledgements

Scope

W.S. 28-8-107(b) authorizes the Legislative Service Office to conduct program evaluations, performance audits, and analyses of policy alternatives. Generally, the purpose of such research is to provide a base of knowledge from which policymakers can make informed decisions.

In December 2006, the Management Audit Committee directed staff to undertake a review of the state's children's health care program known as Kid Care CHIP. Kid Care CHIP is the Wyoming variant of a federal government block grant program called SCHIP, the State Children's Health Insurance Program. The Committee requested an analysis focusing on the following questions:

- How is Kid Care CHIP organized and funded?
- How many children are enrolled in the program and what benefits do they receive? Are they using preventive health care services?
- How does the program work, and how does it differ from EqualityCare (Medicaid)?
- What assurances are there that children are not enrolled in both Kid Care CHIP and EqualityCare?
- Do policymakers have sufficient information to make important policy decisions about Kid Care CHIP?

Acknowledgements

The Legislative Service Office expresses appreciation to those who assisted in this research, including Kid Care CHIP staff and other officials and staff at the Department of Health and the Office of Healthcare Financing; the Departments of Family

Services and Administration and Information; members of the Health Benefits Plan Committee; and Blue Cross Blue Shield of Wyoming and Delta Dental.

CHAPTER 1

Background

Kid Care CHIP provides low-income children access to health insurance

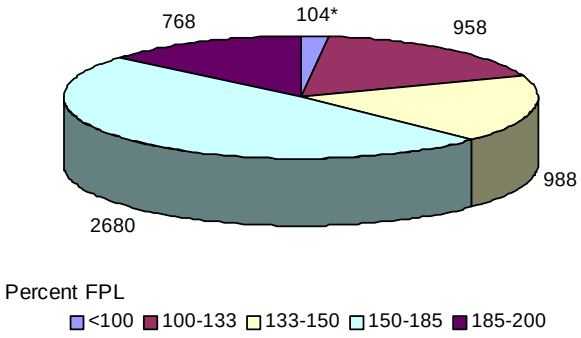
Kid Care CHIP provides health insurance coverage to children in families whose income is too high to qualify for EqualityCare (Medicaid), but is still at or below 200 percent of the federal poverty level (FPL). The program serves children in families of the working poor and near poor: from April 2006 through March 2007, children in a family of four with an income of $40,000 or less per year were eligible. The Legislature first created the program in 1999 and substantially revised it in 2003 (see Appendix A, W.S. 35-25-101 through 111).

Nearly 5,500 children were enrolled on February 1, 2007.

On February 1, 2007, nearly 5,500 children from 3,262 low-income households were enrolled in Kid Care CHIP. Figure 1.1 shows the distribution of enrollees by family income (see Appendix B for additional description of participants and families).

Figure 1.1

Kid Care CHIP participants by family income
February 2007



*The 104 participants below 100 percent FPL shown in the figure are resident aliens, eligible for Kid Care but not for EqualityCare because of their citizenship status.

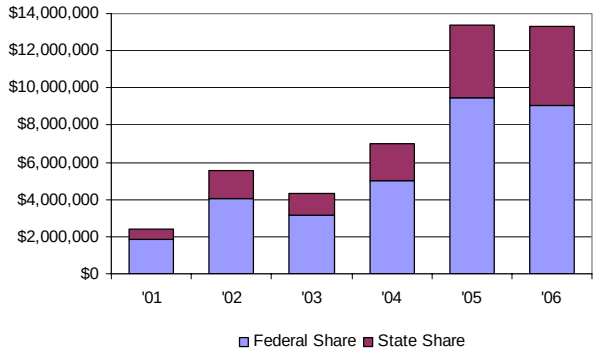
Source: LSO analysis of Kid Care CHIP applications

The WDH (Wyoming Department of Health) administers Kid Care CHIP through the Office of Healthcare Financing. The program's ten staff are responsible for eligibility determinations, outreach, education, and managing the insurance contract. Its budget of $27.3 million for FY '07 - '08 comes from state and federal funding sources. Figure 1.2 shows the increase in biennial funding since inception.

Program funding increased in the '05-'06 biennium.

Figure 1.2

State and federal appropriations for Kid Care CHIP
State Fiscal Year '01 – '06



Source: LSO analysis of Kid Care CHIP data

Congress created SCHIP in 1997

Congress gave states flexibility in program design.

Congress created the State Children's Health Insurance Program (SCHIP) in 1997 and gave states flexibility in determining eligibility, benefit levels, and program design. To provide access to health benefits for low-income children not eligible for Medicaid, states could use SCHIP to expand their Medicaid programs, set up separate health care programs, or design a program using the two approaches. Medicaid expansion programs are subject to Medicaid rules and restrictions; separate health care programs can tailor benefits and services to a target population, but must receive federal approval. Wyoming is one of 18 states with a separate program, while 11 states have Medicaid expansions and the remaining 21 states have programs that combine the two approaches.

Wyoming's name for its SCHIP program is "Kid Care CHIP."

In this report, when describing the federal program, we refer to "SCHIP" to distinguish it from Wyoming's "Kid Care CHIP." Similarly, we use "Medicaid" to describe the federal program, and "EqualityCare" to describe Wyoming's Medicaid program.

Reauthorization may bring changes.

With SCHIP's authorization ending on September 30, 2007, Congress is considering a number of issues such as its funding level and formula and eligible populations. Regarding eligibility, there is as yet no consensus on issues such as whether states should be allowed to cover adults under SCHIP, and whether eligibility for children should expand to higher income levels.

Federal funding

When creating the program in 1997, Congress allocated $40 billion to be disbursed over a 10-year period. States and territories receive an annual allotment based on a funding formula that takes into account the number of uninsured low-income children and the total number of low-income children in each state. States have three years to use the allotment, after which the funding is redistributed to states that have used theirs. Because Wyoming started its program later than other states did, it was slower to use initial allotments and thus returned over $16 million from federal fiscal years 1998 through 2002. Since then, the program has not returned federal funds.

Federal matching rates are higher for SCHIP than for Medicaid.

The federal government matches state SCHIP funding at a higher percentage rate than for Medicaid. The Medicaid rate is known as FMAP (Federal Medical Assistance Percentage), while the higher reimbursement rate for SCHIP is known as an Enhanced FMAP. For federal fiscal year 2007, Wyoming's Enhanced FMAP is 67 percent, with the Enhanced FMAP applicable to administrative costs up to 10 percent of total expenditures.

Wyoming's program has changed

Wyoming's first SCHIP as created in 1999 had two parts: a voucher program and a Medicaid look-alike program that offered the same benefits as Medicaid, but was separate from it. Due to difficulties in implementing the voucher approach, in 2003 the Legislature repealed the 1999 statute and recreated the program.

Figure 1.3

Kid Care Chip and EqualityCare

	Kid Care CHIP	EqualityCare
'05 -'06 appropriation **Federal share** **State share**	$26,698,789 $18,489,129 $ 8,209,662	$356,696,653
'07–'08 FMAP rates **FFY 2007** **FFY 2008**	 67.04% 65.00%	 52.91% 50.00%
Federal funding payment method	Capped allotment to state	Entitlement
Method of paying for health services	WDH pays premiums to Blue Cross Blue Shield; BCBS pays providers	Fee for service
Enrollment of low-income children February 1, 2007	5,498 children	31,059 children
Cost sharing	$5 co-payments for certain services, with a maximum of $200 per family per year	None
Income eligibility, children birth through 5	134% through 200% FPL	Under 133% FPL
Income eligibility, children age 6 through 18	101% through 200% FPL	Under 100% FPL
Citizenship requirements	Citizens, resident aliens	Citizens
Determines eligibility	Department of Health/Kid Care CHIP	Department of Family Services local offices

Source: LSO summary of A&I, Kid Care CHIP and EqualityCare documents

The Legislature has steadily increased income limits for Kid Care CHIP eligibility.

Under the 1999 law, the income eligibility limit was 150 percent of FPL. In 2003, the Legislature increased the upper income limits for enrollees: through June 30, 2005, children could be enrolled with incomes up to 185 percent FPL, after which the limit went up to 200 percent FPL (see Appendix C for current poverty guidelines and other states' eligibility limits). Because the Legislature raised income limits and also approved fundamental structural changes in 2003, Kid Care CHIP is a relatively new program. This report focuses on evaluating the program as it has developed since 2003, but also includes historical and contextual information since 1999.

In 2006, Wyoming's Legislature authorized application to the federal Centers for Medicare and Medicaid Services for a waiver to extend Kid Care CHIP eligibility to parents and guardians of children in Kid Care CHIP and EqualityCare. It is likely that the waiver decision will not be made until after Congress makes a decision on SCHIP reauthorization.

Kid Care CHIP and EqualityCare provide health insurance to low-income children

The two programs provide health benefits to different low-income populations.

The Legislature and WDH designed Kid Care CHIP to complement EqualityCare for children, not overlap with it: both programs provide health benefits, but to different segments of Wyoming's population of low-income children. EqualityCare operates on a larger scale than Kid Care CHIP because in addition to insuring children, it also provides benefits to low-income parents, pregnant women, senior citizens, blind and disabled, and other federally-mandated populations. By contrast, Kid Care CHIP is available only to children, and only until they are 19. Figure 1.3 compares features of the two programs.

Children in the same family can be enrolled in different programs.

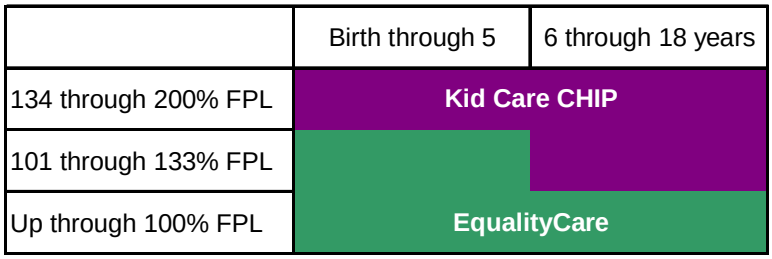
EqualityCare's income eligibility ceiling for low-income children defines Kid Care CHIP's eligibility floor (100 or 133 percent of FPL, depending on the child's age). As shown in Figure 1.4, Kid Care CHIP insures children with incomes above EqualityCare's upper limits, but at or below 200 percent FPL. Families can have children in both programs. For example, if a family's income is at 125 percent of the FPL, their two year-old child is eligible for EqualityCare and their seven year old is

eligible for Kid Care CHIP. In the month of January 2007, 49 percent of the families who enrolled their children in Kid Care CHIP also had children in EqualityCare.

Kid Care CHIP's income eligibility floor is EqualityCare's income ceiling.

Figure 1. 4

Kid Care CHIP and EqualityCare eligibility



Source: Kid Care CHIP documents

Federal and state rules set strict eligibility criteria

To be eligible for Kid Care CHIP, a child must:

- be less than 19 years old
- be a member of a family whose income is at or below 200 percent of FPL
- be a U.S citizen or have lived in the U.S. legally for at least five years
- be a state resident
- not have had health insurance for one month, or must provide a valid reason for canceling, such as the parent losing his/her job and with it, the insurance
- not be eligible for EqualityCare
- not be a resident of a public institution such as the Wyoming Boys' School, or an institution for mental illness such as the State Hospital
- not be the child of a state employee

The Health Benefits Plan Committee sets benefits

W.S. 35-25-105 requires a Health Benefits Plan Committee to determine the benefits package for Kid Care CHIP participants. The committee has ten members who represent the public, the medical community, and the insurance industry, and staff from the Departments of Health, Insurance, and Family Services. It meets at least every other year to review and modify the benefits package (see Appendix D for a list of benefits).

Families make nominal contributions to the cost of care.

Kid Care CHIP families are responsible for contributing to the cost of care in the form of $5 co-payments at the time of service. The program limits co-payments to $200 per family per year. Some services, such as well-child visits, are exempt from the co-payment requirement. Native Americans are exempt from co-payments.

Blue Cross Blue Shield administers benefits

Since program restructuring in 2003, Kid Care CHIP has contracted with Blue Cross Blue Shield of Wyoming (BCBS) to administer the health benefits. BCBS sub-contracts with Delta Dental to provide dental coverage. Kid Care CHIP pays monthly premiums to BCBS. For FY '07, the premium is $157.65 per child per month ($1,892 per child per year); in FY '06 this amounted to $8.2 million paid to BCBS.

Each participant gets an identification card from Blue Cross Blue Shield.

In addition to processing and paying claims for enrollees' medical services, BCBS issues identification cards and enrollee handbooks, maintains a statewide provider network, and tracks co-payments. BCBS pays providers in this network a negotiated rate for services delivered to Kid Care CHIP enrollees. The current contract expires on June 30, 2007, and Kid Care CHIP has issued a request for proposals for the next contract.

Outreach efforts were funded by a grant

Between 1999 and 2006, the Robert Wood Johnson Foundation awarded two grants totaling nearly $1.6 million to Wyoming. Funding supported efforts to develop outreach for Kid Care

Outreach efforts led to the creation of the Covering Kids Coalition.

CHIP and EqualityCare, simplify the application process, and coordinate efforts between the two programs. The grants required the state to work with a coalition of stakeholders. Wyoming's "Covering Kids Coalition" includes medical, dental, and social service organizations and providers, school personnel, business representatives, and staff from WDH and DFS.

The Foundation discontinued these grants in June 2006, and the future of the Coalition is uncertain at this time. It is also unclear what the impact will be on Kid Care CHIP's federally-mandated outreach efforts, which had depended on grant funding and had been directed by the Coalition. Kid Care CHIP now funds outreach from its administrative funds.

Kid Care CHIP determines eligibility

Originally, DFS determined eligibility for Kid Care CHIP.

Families can use WDH or DFS forms to apply for Kid Care CHIP and EqualityCare. Kid Care CHIP applications are available on the program's website as well as at schools and social and health service offices around the state. DFS applications are used to determine eligibility not just for the two health benefits programs, but also for other DFS programs. Families can mail either application to the Kid Care CHIP office in Cheyenne or take it to a DFS office in their area. They can use either application form to apply to either agency for either program. However, only Kid Care CHIP can determine that a child is eligible for its program, and only DFS can determine a child's eligibility for EqualityCare.

Since federal law requires states first to determine if a child is eligible for Medicaid, Kid Care CHIP does a preliminary screen of whether the child appears to be eligible for EqualityCare. Kid Care CHIP sends denied applications to the appropriate local DFS office. If DFS determines that a child's family has too high an income for EqualityCare, they send the application to Kid Care CHIP.

Children must renew annually

The enrollment period is for one year.

Children enrolled in Kid Care CHIP remain eligible for the program for one year unless they are enrolled in other EqualityCare programs such as Foster Care, turn 19, move out

of state, or enter a public institution such as the Wyoming Boys' School. Other children can stay on the program for the year regardless of changes in family circumstances, unless parents provide a written request to be removed from the program. At the end of the one-year enrollment period, participants must renew enrollment by reapplying to the program. Kid Care CHIP staff sends letters reminding participants to renew 60 days and 30 days before their eligibility expires.

Children can transfer between Kid Care CHIP and Equality Care.

At renewal time, some children transfer between Kid Care CHIP and EqualityCare. If a child is on one program but at renewal time is found to be eligible for the other program, staff sends the application form to the other agency. Kid Care CHIP and DFS use different renewal forms, but each accepts the other's form.

Kid Care CHIP has a quality control process

Both EqualityCare and Kid Care CHIP allow applicants to report their income without requiring the applicant to submit forms of verification, such as a pay stub. Kid Care CHIP has a formal quality control process to check the accuracy of applications: each month, a randomly-selected sample of families that enrolled or renewed during the previous month must submit income verification. If the family does not submit verification or if the verification shows the child is not eligible, then the child is dropped from coverage at the end of the month.

Fewer Wyoming children are now uninsured

Estimates of the number of uninsured are imprecise.

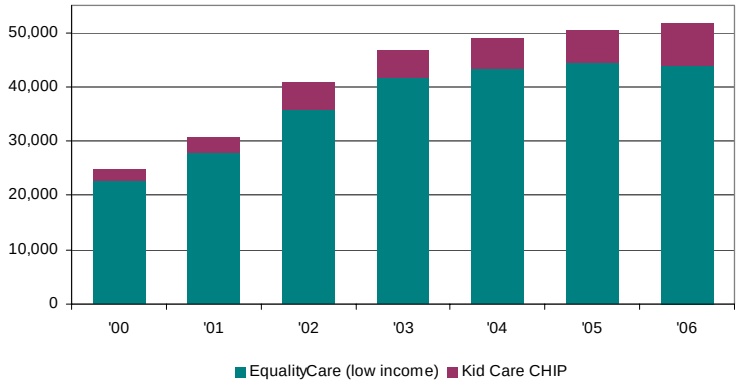
According to data from the U.S. Census Bureau, the estimated number of low-income Wyoming children who are uninsured has declined 50 percent since 1999. Wyoming's average number of uninsured children for 1997-1999 was 12,000; this number went down to 6,000 in 2003-2005. However, the Census Bureau's methods rely on a relatively small sample and thus tend to make the estimates imprecise, especially in states with low populations. The numbers are helpful, though, for seeing trends in the rate of uninsured. Although the exact number in Wyoming is not known, it is clear that the number of low-income uninsured children has dropped markedly since Kid Care CHIP began.

Fully 28 percent of Wyoming's children have public health insurance.

Another way to assess the impact of Kid Care CHIP is to look at the additional number of children who now have insurance. By that measure Kid Care CHIP, with more than 5,000 enrollees, has been successful. In addition, EqualityCare credits Kid Care CHIP outreach efforts for its own increased enrollment: since Kid Care CHIP began, EqualityCare enrollment has doubled for low-income children. Between the two programs, they currently provide health care coverage for 28 percent of children in the state. Figure 1.5 illustrates enrollment changes since 1999.

Figure 1.5

Annual Kid Care CHIP and EqualityCare low-income enrollment
Federal Fiscal Years 1999- 2006



Source: LSO analysis of EqualityCare and Kid Care CHIP data

More children now have access to health care.

Thus, Kid Care CHIP has increased the number of low-income Wyoming children who have health insurance, and also has served as a catalyst for increased participation in EqualityCare. This report examines two additional issues. First, the program is still adapting its procedures and can continue to look for ways to improve them. Second, additional access to and analysis of both its own data and data in other programs can help program managers and policymakers in their decision-making.

CHAPTER 2

Kid Care CHIP is responding to problems and looking for solutions

In this chapter, we focus on two areas of program weakness and Kid Care CHIP's response to them as examples of how the program is addressing issues as they arise. First, some children are enrolled in both Kid Care CHIP and EqualityCare, a duplication that is not allowed under federal law. Having children enrolled in both programs results in unnecessary state and federal expenses as the governments pay to cover the child in both programs. Second, many enrollees are not using preventive health care services, which suggests these children are not receiving the full benefits of having health insurance.

As problems are identified, the program is adapting its procedures.

In both cases, the problems are, in part, a result of the program still fine-tuning its procedures. Kid Care CHIP has recognized the problems and stepped up its efforts in these areas. As the program matures and more challenges arise, we recommend that Kid Care CHIP maintain this responsive and proactive approach and continue to strengthen the state's health care coverage for low-income children.

Kid Care CHIP is working to minimize the number of dually enrolled children

Some children are on both Kid Care CHIP and EqualityCare.

In October 2006, Kid Care CHIP found that 101 of the approximately 5,300 children enrolled at the time were also on EqualityCare. Because DFS makes eligibility decisions for EqualityCare and the Kid Care CHIP program in WDH makes its own eligibility decisions, preventing children from being enrolled in both programs requires the two agencies to work together.

Children should not be enrolled in both programs

No child is eligible for both EqualityCare and Kid Care CHIP at the same time, although eligibility may change on a daily basis with fluctuations in a family's income or other circumstances. According to federal law, states will not be paid for insuring a

child through SCHIP if that child has private insurance or is insured through any other federally financed health care insurance program except the Indian Health Service. Thus, the federal government will not provide funding to both Medicaid and SCHIP for the same child. Federal law and regulations require SCHIP and Medicaid programs to coordinate to ensure children are enrolled in the appropriate program.

Federal law requires Medicaid and SCHIP to coordinate.

Dual enrollments occur for different reasons

Kid Care CHIP has developed a process intended to prevent children from being enrolled in both programs. Before enrolling a child, staff check DFS' EPICS (Eligibility Payment Information Computer System) twice to see if that child is already on EqualityCare: first when making the eligibility decision and again before enrolling the child. Similarly, DFS staff check an electronic list of all Kid Care CHIP enrollees; every month, Kid Care CHIP sends DFS a list of enrolled children for that purpose.

Despite these efforts, some children are still being enrolled in both programs. We identified two reasons. First, the children may be on Kid Care CHIP but when circumstances change, they become eligible for EqualityCare. For example, when children go into foster care or are approved for SSI (Supplemental Security Income), they are automatically eligible for EqualityCare. DFS should notify Kid Care CHIP to drop the child's coverage before enrollment in EqualityCare begins, but this does not always happen.

Changes in a child's family situation can affect eligibility.

Second, a family's income may change so the children become eligible for the other program. If a child is on Kid Care CHIP when the family income drops to EqualityCare levels, the child may stay on Kid Care CHIP until renewal – or the parent may apply for EqualityCare for the child. The program enrolling a child should make sure the child is not also on the other program.

Anticipated system improvements should help

DFS expects its planned eligibility system, IRIS (Integrated Resource Information System), to reduce the number of dually enrolled children. As of this writing, DFS expects IRIS to be completed in 2008. As planned, IRIS and Kid Care CHIP's

eligibility system will communicate, thus giving DFS staff more up-to-date information than the current monthly list of Kid Care CHIP enrollees.

In addition to having procedures to prevent children from being enrolled in both programs, Kid Care CHIP also has procedures for catching dual enrollment. In the past, once or twice a year, program staff manually searched EPICS for every child on Kid Care CHIP to see if that child was also on EqualityCare.

Kid Care CHIP recently developed a new check for dual enrollments.

Kid Care CHIP has introduced a new procedure expected to help catch dual enrollees more quickly by working with ACS, the contractor responsible for processing claims for EqualityCare. For several years, ACS has searched for dual enrollees using its system and a list of Kid Care CHIP participants that is updated monthly. If a child is on both programs, ACS does not pay that child's medical claim. Recently, Kid Care CHIP staff has begun reviewing the ACS report of dually enrolled children and then consulting with DFS staff to determine the appropriate program for the child. This procedure should help identify dual enrollments quickly so they can be acted on and resolved.

The problem of dual enrollment has been relatively small. The 101 dual enrollees from October 2006 constituted two percent of Kid Care CHIP enrollees, and only a quarter of one percent of children on EqualityCare. Nevertheless, having children enrolled in both EqualityCare and Kid Care CHIP results in unnecessary expenditures, such as duplicate administrative costs when enrolling children in both programs.

Kid Care CHIP encourages use of preventive health care services, but use is still low

Many enrolled children are not using well-child care.

Another challenge for Kid Care CHIP is that many enrollees do not use recommended well-child care. As with the problem of having children enrolled in both health insurance programs, program managers have identified this as an issue and are working to resolve it. The program cannot require families to use well-child care but it can encourage them to do so, and Kid Care CHIP has recently implemented new strategies to encourage increased use of well-child care.

Academic research shows the value of preventive care

One type of health care that can improve children's health is well-child visits. Well-child visits are important for many reasons, from identifying and monitoring medical and developmental conditions, to educating parents. The American Academy of Pediatrics recommends that children under the age of six should receive at least one well-child visit each year, depending on their age. Children under the age of two should receive more frequent well-child care.

Research shows a connection between well-child care and children's health.

Academic research has identified a relationship between use of well-child visits, reductions in avoidable hospitalizations and emergency room use, and improved health. However, if Kid Care CHIP enrollees are not accessing the services that could help make them healthier, then they are not receiving the full benefits of insurance.

Enrollees are using health care, but many are not using well-child care

Although the American Academy of Pediatrics recommends annual well-child visits for children under six, not all children receive those visits. Nationally, an academic study in the journal *Pediatrics* found that 44 percent of all children received a well-child visit in a year. It found that younger children tend to receive higher rates of this service: 82 percent of children under the age of one had a well-child visit, compared to 51 percent of children age three to five.

Kid Care CHIP enrollees use well-child care at less than the national rate.

In Wyoming, Kid Care CHIP's rate of well-child visits is lower than the national rate. The program's 2006 Annual Report to CMS states that 41 percent of enrolled children under the age of 15 months used their Kid Care CHIP coverage to get a well-child visit in federal fiscal year 2006. The rate is even lower for children age three to six years: only 22 percent of them had a well-child visit during that time.

Although Kid Care CHIP enrollees have low rates of well-child visits, these children are using health care services. Figure 2.1 shows selected preventive and treatment health services provided to Kid Care CHIP enrollees between July 1, 2005 and June 30, 2006, and how many children received those services. A total of 7,507 children were on Kid Care CHIP for at least part of that

More than 80 percent of enrolled children used at least one health care service.

year.[1] Of these children, 6,157 or 82 percent used at least one health care service, although most of them were not preventive. For example, more children went to the emergency room than had a well-child visit during this year. Also, almost half of the children who had a dental cleaning had a filling, and about half of enrolled children had at least one prescription.

Figure 2.1

Health care services used by Kid Care CHIP enrollees SFY 2006

Health Care Service	Number of Services	Number of Children Served
Immunizations	3,131	1,017
Well-Child Visits	1,480	1,300
Dental Cleaning	3,129	2,738
Dental Fillings	3,349	1,332
Emergency Room Visits	1,974	1,334
Prescriptions	22,263	3,980

Source: Blue Cross Blue Shield and Delta Dental data

The program is promoting use of well-child care

Kid Care CHIP makes efforts to educate parents about well-child care.

Kid Care CHIP has annual goals for increasing the use of well-child care. Although the program cannot mandate that parents take their children in for well-child visits, it can work to make services available and to educate parents about their value. In the past year, Kid Care CHIP has implemented new strategies for educating families about the importance of well-child care. It mails a quarterly newsletter on health issues to enrolled families, and has begun sending a letter to parents on their child's third through sixth birthdays; these birthday letters remind parents of the importance of well-child care. Kid Care CHIP has also begun sending a letter to the parents of all enrolled newborns about the importance of immunizations. Since these strategies were implemented recently, the extent to which they may contribute to greater use of preventive services is not yet known.

[1] This number is higher than the 5,498 enrolled children cited in Chapter 1 because some left the program and others joined during the course of the year.

Kid Care CHIP is still fine-tuning its processes

Kid Care CHIP has existed in its current structure since 2003, when the Legislature revised statute to transfer responsibility for determining eligibility from DFS to WDH. Since then, Kid Care CHIP has been developing procedures for determining eligibility and for coordinating with DFS to ensure that children are not enrolled in both programs. It also has begun to focus on increasing the number of children receiving well-child care by ramping up educational efforts.

Recommendation: Kid Care CHIP should continue to look for ways to improve.

Staff should monitor improvement strategies.

Kid Care CHIP has taken steps to improve the program by identifying areas of weakness and working to address these issues. Staff should continue to look for improvement opportunities as the program becomes more established; this is especially important given possible changes on the horizon at the national level. Staff should also monitor data to determine whether improvement strategies are effective. The following chapter discusses ways the program could use data more effectively.

CHAPTER 3

Kid Care CHIP can improve use of available data to inform development and process decisions

Kid Care CHIP has had limited access to program data.

Through its everyday activities, Kid Care CHIP collects information that could help demonstrate progress toward goals, and also could help identify procedural roadblocks. To date, however, use of this information has focused primarily on measuring workloads and producing general program descriptions. In part, this is because Kid Care CHIP staff has limited access to the data collected by and stored in the computer system on which they rely, making it difficult for them to conduct in-depth analysis. Other state programs also collect information that Kid Care CHIP could use, if it developed that capacity.

Limited use of administrative data means the program is not fully using a valuable source of information that could enhance self-assessment efforts and help focus resource use. We recommend that Kid Care CHIP develop greater access to the administrative data resources available through its own and other programs.

Comprehensive information is necessary to make continuous improvements

Good information helps identify problems and solutions.

Accurate and timely information is an essential component of a program's ability to make sound decisions on policy direction, set priorities, and allocate resources. Good information also contributes to early identification of procedural problems and is increasingly in demand at both the state and federal levels to demonstrate program accountability. Administrative data is the least expensive and most readily available source of program-related information; every program generates it in one format or another in the course of daily operations.

Kid Care CHIP collects administrative data

Decisions on applications, eligibility determinations, quality control activities, re-enrollments, application denials and case

closures generate detailed information on applicants and enrollees. Thus, Kid Care CHIP administrative procedures already produce information that fulfills federal and state reporting requirements.

Federal funding requires programs to report on performance.

- Federal funding requires each participating state to have an approved plan that includes: a description of strategic objectives; performance goals; and state-established performance measures for providing child health assistance to targeted low-income children. CMS (the federal Centers for Medicare and Medicaid Services) also requires an annual progress report.

State law requires performance data.

- At the state level, W.S. 28-1-115 through 116 requires state government programs to report on performance-based measurements. In addition, W.S. 35-25-108(a)(v) specifically requires Kid Care CHIP to "…establish indicators for measuring access, process quality and outcomes effectiveness in improving children's health."

Some important data is not easily accessible or in a flexible format

The KIDS data system was designed to determine eligibility, not analyze data.

As required by federal and state law, Kid Care CHIP is collecting performance and program data. Data on applicants and enrollees is maintained in a computer system called KIDS (the Kids Information Determination System). It has a considerable amount of data on applicants and enrollees, and can produce basic reports such as operational reports on workload and processing time, and broad summaries that show the total number of applicants, enrollees, and closures. However, because the system's primary purpose is to make eligibility decisions, there are some limitations to using KIDS data. For example, it has only a limited ability to produce reports that summarize the characteristics of all enrollees or that list all enrollees with a particular characteristic.

To create additional reports, Kid Care CHIP must pay its contractor a fee, which requires expenditure of additional administrative funds. The practical outcome is that staff does not request extra reports and do not query the system as new questions arise. They can look up information on specific participants and

their families but are limited in their ability to look at data on a program level.

Blue Cross Blue Shield tracks use of services and costs.

Blue Cross Blue Shield tracks individual enrollee use and cost of health services, and provides this data in hard copy, quarterly. Kid Care CHIP staff can look at these data from an accounting perspective to see where funds are being spent, how many individuals use services, and which participants have used enough services to meet co-pay caps. However, the paper format of this information does not allow managers to manipulate data in order to examine program trends and overall use patterns in relation to Kid Care CHIP goals, unless they enter the data into a new spreadsheet.

Kid Care CHIP needs full information to make program decisions and answer questions

Upcoming changes call for informed responses.

Kid Care CHIP is facing many changes that may have important implications for its future funding and operations. First, Wyoming's enhanced FMAP is declining, so the state will pay a larger share of Kid Care CHIP's costs. Second, without Robert Wood Johnson grant funds, Kid Care CHIP now must fund outreach from its own administrative budget. Third, as part of federal reauthorization of SCHIP, funding levels, methods, and eligibility requirements could change. Fourth, if CMS approves Wyoming's waiver, some low-income parents and guardians will be eligible for Kid Care CHIP. If the program reaches the legislative cap of 3,700 participants, this would considerably increase its size, cost, and workload.

KIDS captures and stores extensive information that could help program managers and policymakers respond to changes. The system has data to describe the current and historical applications, enrollments, and demographics. However, the information can only be accessed by looking at individual family records or by using the basic reports that already exist. Staff continues to work with the contractor to make improvements to KIDS, but to date these changes have focused on eligibility processing and improving existing reports, not on developing the capacity to create their own reports as needed.

Answering additional questions requires new expenditures.

Consequently, we were unable to answer certain basic questions about participants and program dynamics without requesting the program to spend additional administrative funds to extract data from KIDS. This is a concern because Kid Care CHIP may increasingly be required to demonstrate its accomplishments to state and federal policymakers. The following are some examples of our questions:

- How long are children enrolled in Kid Care CHIP?
- How many applicants who are ineligible for Kid Care CHIP are potentially eligible for EqualityCare?
- How many applicants not eligible for Kid Care CHIP would be eligible if the percent FPL cap were increased?
- Are children being transitioned smoothly between EqualityCare and Kid Care CHIP?
- How many parents of children in the program report having health insurance?

Reports are not always dependable

Kid Care CHIP does not control access to its own data.

The current development status of the KIDS system means that Kid Care CHIP does not directly control access to its own data, which limits the data's usefulness. Furthermore, some of the reports as produced have been problematic. For example, the total number of children did not agree among various reports given to us during research, even though they purported to count the same participants, characteristics, and time periods.

Additionally, some available information is not as useful as it could be**.** Standard reports that Kid Care CHIP provided us combined new enrollees and renewing participants in the same category, "new enrollees." This gives an inflated view of the number of new children entering the program. Although program data for January 2007 showed 474 new enrollees, our review of applications for that month showed as many as 64 percent of applicants may have been re-enrollees, not new enrollees: 34 percent of applicants clearly were re-enrolling, and as many as another 30 percent appeared to be re-enrollees. More importantly, combining these categories makes it difficult to assess

the effectiveness of program outreach and retention strategies, meaning staff cannot accurately gauge where to focus efforts and resources.

To enroll and retain the target population, the program needs complete data

Good information and analysis help programs target their resources.

Effective outreach and eligibility verification procedures are critical to getting families to enroll and retain their eligible children in the program. They also help ensure that only those children who are eligible are enrolled. To be most successful, outreach projects need to be targeted to areas and populations where there is the most possibility of new enrollments. By reviewing historical enrollment data to identify the effects of the Robert Wood Johnson-funded pilot projects, Kid Care CHIP can determine which were most successful. For instance, this data might help explain why Crook County has the highest proportion of participants in the program, without having had a pilot project (see Appendix B). A review of demographic data can also help identify regions or populations that still need targeted efforts.

According to program projections, if the federal government continues funding Kid Care CHIP at current levels, Wyoming will soon have a waiting list. In that case, procedures will need to be as efficient as possible in distinguishing, for example, between eligible and ineligible applicants. Also, since families can submit an application for Kid Care CHIP or EqualityCare to either DFS or WDH, the two departments frequently send applications back and forth. There is potential for applications to be inadvertently lost, yet neither department appears to be tracking applications to see what happens once referral to the other program takes place.

Good data access can enhance decision-making.

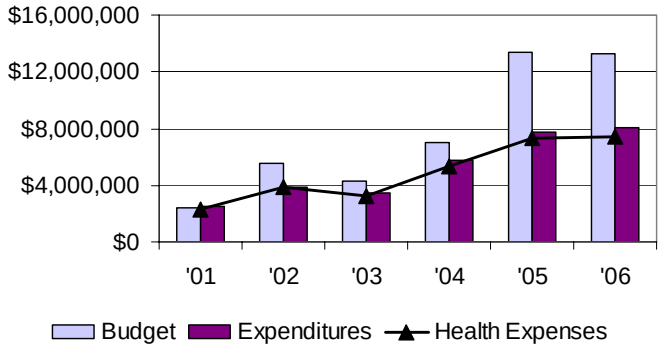
Department officials state they are trying to keep administrative spending low because they would rather spend funding on insuring children than improving computer systems. We agree that insuring children is an appropriate and important goal. However, we also believe that greater access to and use of data can improve decision-making for program managers and policymakers. This will enhance the program's ability to use limited resources effectively, to insure children.

Administrative funding could support more data access.

Throughout its history, Kid Care CHIP has underspent both its federal allotment and its state funds. Figure 3.1 illustrates how effective the program has been in making sure its expenditures go directly to health expenses. It also shows that funds have been available to develop additional reports to support analysis and problem-solving. Instead, in the '05-'06 biennium, unexpended General Funds from Kid Care CHIP were transferred to other WDH health programs.

Figure 3.1

Kid Care CHIP appropriations and expenditures SFY '00 – '06



Source: Kid Care CHIP budget and expenditure data

Data-sharing with other agencies can improve Kid Care CHIP eligibility, outreach

Although Kid Care CHIP relies on self declaration and does not verify income information at the time of application, it could use both its own and other programs' administrative data in the quality control process. Kid Care CHIP's quality control reviews focus on a sample of new enrollees each month, in an effort to identify participants who may be under- or over-income, already have private health insurance, or be enrolled in EqualityCare.

Other programs share similar goals and have valuable information to offer.

SCHIP programs in other states have worked with CSE (Child Support Enforcement) agencies to verify wage and employment records, and check availability of private insurance to children of divorced parents. SCHIP and CSE share the goals of ensuring that children have access to health care and healthy outcomes.

Collaborative efforts can help all participants.

SCHIP provides insurance to children whose parents' employment or financial situations do not allow for private insurance coverage. CSE ensures that non-custodial parents contribute to their children's financial and medical support. By working together, they can make certain that children whose non-custodial parent is required to purchase private insurance are not instead enrolled in public programs. Collaboration could also help CSE comply with federal medical support performance goals.

Kid Care CHIP works with CSE, sending them a list of participants so that CSE can manually identify those children in their computer system. We believe there are additional opportunities for collaboration between the two programs. For example, CSE could help Kid Care CHIP with education and outreach efforts.

School-level data could help this program target its outreach efforts

The program could also benefit from cooperative exchanges of information with other programs. The Department of Education maintains data on the percent of children at each school who are eligible for the School Lunch Program. School-level data could help Kid Care CHIP target outreach and education efforts to schools with concentrations of low-income uninsured children.

Recommendation: Kid Care CHIP should develop better access to existing administrative data.

Kid Care CHIP should identify the information that it needs to address program performance questions as they arise, and work to develop access to those resources – whether in their own or other state data systems. Internally, this will require the program to strengthen its capacity to use its own data. Externally, Kid Care CHIP should explore the potential for developing more formal working relationships which include exchanging information with other programs. In short, we are proposing that the program expand its view of how to use data and explore new ways to incorporate existing information, for the mutual benefit of Kid Care CHIP, other programs, and the children they serve.

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CHAPTER 4

Conclusion

In eight years, Kid Care CHIP has contributed substantially to increasing the number of low-income children who have health insurance. This has occurred directly through Kid Care CHIP enrollments, and indirectly through large increases in EqualityCare enrollments. As of February 1, 2007, more than 36,000 low-income children had access to medical care through these two programs: 5,498 in Kid Care CHIP, and another 31,059 in EqualityCare.

Achieving a reduction in the number of uninsured low-income children has occurred in part because the Legislature has expanded coverage for children several times, and also because outreach efforts have been successful. In 1999, public health insurance was available only for children in families with incomes up to 100 or 133 percent FPL, depending on the child's age. Since then, the Legislature has expanded eligibility for Kid Care CHIP; now, children under 200 percent FPL can receive health care coverage either through EqualityCare or Kid Care CHIP, depending on the family's income. Aided by Kid Care CHIP's outreach efforts, participation in low-income Equality-Care for children has nearly doubled in the past eight years. These changes have occurred during the same period of time in which Wyoming's under-19 population declined by nine percent.

Overall, we were impressed with Kid Care CHIP's operations and staff. Our review of Kid Care CHIP comes at an important time for the program, with Congress considering SCHIP reauthorization as well as changes to funding amounts and distribution methods. Should Congress decide to reduce or eliminate funding for SCHIP, Wyoming's Legislature will have to consider how best to use state appropriations to meet the program's goals. This report provides information on program successes and limitations that can inform the Legislature's future deliberations. We conclude that Kid Care CHIP has been effective in reducing the number of uninsured children in the state, and is taking steps to refine and improve its operations.

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AGENCY RESPONSE

Kid Care CHIP: Wyoming's State Children's Health Insurance Program

Wyoming Department of Health

Commit to your health.
visit www.health.wyo.gov

Brent D. Sherard, M.D., M.P.H., Director and State Health Officer

Governor Dave Freudenthal

MEMORANDUM

Date: May 30, 2007

To: Senator John Schiffer, Chairman, Management Audit Committee

From: Brent D. Sherard, M.D., M.P.H., Director and State Health Officer
Wyoming Department of Health

Subject: Wyoming Department of Health, Kid Care CHIP – Report Response

Ref: S-2007-468

Please find attached the Wyoming Department of Health, Kid Care CHIP's response to the Management Audit Committee report as requested by the Legislative Service Office.

Please contact me at (307) 777-7656 if you have any questions regarding this report.

BDS/PG/jg

Attachment

c: Chris Boswell, Chief of Staff, Office of the Governor
Lee Clabots, M.S.Hyg., M.P.H., Deputy Director of Administration
Wendy Curran, Health Policy Analyst, Office of the Governor
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Wyoming Department of Health
Kid Care Children's Health Insurance Program (CHIP)
Report Response
May 30, 2007

Recommendation: The Kid Care Children's Health Program (CHIP) should continue to look for ways to improve.

Kid Care CHIP has taken steps to improve the program by identifying areas of weakness and working to address these issues. Staff should continue to look for improvement opportunities as the program becomes more established; this is especially important given possible changes on the horizon at the national level. Staff should also monitor data to determine whether improvement strategies are effective.

Response: The Wyoming Department of Health partially agrees with this recommendation.

- The Wyoming Department of Health, Kid Care CHIP continues to work on ways to evaluate and improve any areas of weakness.

- Within chapter two (pages 11-13) there is discussion regarding duplicate coverage of children. The program acknowledges that duplication of enrollees has occurred and as the report indicates the program has stepped up its efforts in these areas.

- Most duplicates occur after a child is already enrolled in Kid Care CHIP. When family's circumstances change and the family applies for EqualityCare with the Department of Family Services (DFS), a DFS staff should review the Kid Care CHIP eligibility file to ensure the child(ren) are not already enrolled in Kid Care CHIP before they enroll a child into EqualityCare. This does not always happen. Kid Care CHIP staff have implemented steps to ensure that this duplication is kept to a minimum:

    - Kid Care CHIP staff check DFS's Eligibility Payment Information Computer System (EPICS) twice each month. This includes first, at the time an application is received in the Kid Care CHIP office and second at the end of the month prior to the eligibility file being sent to Blue Cross Blue Shield of Wyoming. This double check helps the program to ensure a child has not been enrolled in EqualityCare during the month.

    - Each month Kid Care CHIP sends a file of all eligibles to ACS (EqualityCare's fiscal agent) and an edit was also set up in the MMIS (EqualityCare's claim payment system) so that if a child is enrolled in EqualityCare while they are on Kid Care CHIP, no claims will be paid.

    - Kid Care CHIP receives a report from ACS that shows any potential duplicates. Kid Care CHIP staff checks again to ensure that children are not dually enrolled.

- The evaluation staff indicated *(Page 13, Paragraph 4)* "having children enrolled in both EqualityCare and Kid Care CHIP results in unnecessary expenditures, such as duplicate administrative costs...." Through the numerous checks that Kid Care CHIP does each month and with the edits that are in place, no duplicate payments are being made.

- Within chapter two *(pages 13-15)* there is discussion of preventive health care services. Kid Care CHIP acknowledges that utilization reports for the program indicate that not all children are using their wellness benefits. The program is working to ensure services are available and continues to educate parents about the value of preventive care not only through the program but also through its many partners across the state. These partners include: Blue Cross Blue Shield of Wyoming, Delta Dental of Wyoming, Public Health Nursing Services, Women, Infants, and Children program (WIC), school nurses, etc.

    - Whether a child received their appropriate wellness/preventive care, analyzing data at any one point in time, such as at one year, is difficult. There are many reasons why a child may not have had a visit during a federal or state fiscal year. A child that is eligible during that time period may not have been scheduled for a preventive visit, a child may have received their preventive visit prior to coming onto Kid Care CHIP (such as through EqualityCare) or may have received it from another source such as Public Health Nursing Services.

Recommendation: Kid Care CHIP should develop better access to existing administrative data.

Kid Care CHIP should identify the information that it needs to address program performance questions as they arise and work to develop access to those resources – whether in their own or other state data systems. Internally this will require the program to strengthen its capacity to use its own data. Externally Kid Care CHIP should explore the potential for developing more formal working relationships which include exchanging information with other programs. In short, we are proposing that the program expand its view of how to use data and explore new ways to incorporate existing information, for the mutual benefit of Kid Care CHIP, other programs and the children they serve.

Response: The Wyoming Department of Health, Kid Care CHIP partially agrees with this recommendation.

- The program is working to identify the information that it needs so that it can address any performance questions as they arise. As the report indicates, the program does produce information that fulfills all federal and state reporting requirements.

- The ability to strengthen the program's capacity to use its own data both internally and externally is an ongoing process and a priority for the Department. The program realizes accurate and timely data benefits the program, the Department and the Legislature, and is working hard to build upon the data and create access to additional data.

- The program works with many programs within the Department of Health as well as outside the Department which includes exchanges of information. Kid Care CHIP will continue to explore new ways to work with these programs and others in the state, to ensure that the program is utilizing the data and information in the best way possible for the children served.

- Kid Care CHIP's eligibility system, "KIDS," is fairly new as the program purchased it from Montana SCHIP in late 2003. The system's main purpose is to determine eligibility. Therefore, the first priority was to ensure that eligibility was determined efficiently and effectively.

- It is indicated within this chapter *(page 18, paragraph 2 under "Some Important data is not easily accessible or in a flexible format")* that Kid Care CHIP staff do not request extra reports and do not query the eligibility system as new questions arise. New questions and inquiries surface all the time and Kid Care CHIP does request new reports when the need arises. Most of the information the evaluation staff requested is housed within the system, it is just a matter of creating a new report to pull the data. Since ad-hoc reporting is currently not a piece of the eligibility system, it does require Kid Care CHIP to pay to create new reports. This type of reporting is on the program's list of future enhancements.

- The evaluation staff states *(page 20 paragraph 1)* that they were unable to answer certain basic questions about participants and program dynamics without requesting the program to spend additional administrative funds to extract data from KIDS. At the time in which the evaluation team was reviewing the program, some of the specific reports (enrollment, closures and denials) were being updated and therefore not available whereas other reports have not yet been created. However, the system does capture the data that the evaluation staff was looking for.

    - *How long are children enrolled in Kid Care CHIP?* The "KIDS" system captures data on each child and creates a "family span" when they become eligible. Each child enrolled in Kid Care CHIP receives 12 months of continuous coverage. There are many children that renew each year and receive another 12 months of coverage. Kid Care CHIP is working to create a report to identify how many children renew coverage and for the length of their enrollment.

    - *How many applicants who are ineligible for Kid Care CHIP are potentially eligible for EqualityCare?* The "KIDS" system captures and collects data on each child's eligibility status. If a child is denied or closed because they are under income for the program, Kid Care CHIP is able to identify those children through the denial or closure reports. In data supplied to the evaluation staff for SFY 06, Kid Care CHIP shows that 2,708 children were denied and/or closed for being under income and potentially eligible for EqualityCare.

    - *How many applicants not eligible for Kid Care CHIP would be eligible if the percent FPL cap were increased?* The "KIDS" system collects data on every family's FPL whether they are eligible or not and indicates what percentage they are at. At the time of the review, Kid Care CHIP did not have a report created to show this data; however, the program is working to create a report to identify this number.

    - *Are children being transitioned smoothly between EqualityCare and Kid Care CHIP?* This information cannot be captured within the eligibility system. This requires coordination of eligibility between the two agencies, DFS and Health. Kid Care CHIP staff work closely with the DFS staff to ensure that applications are transitioned smoothly between the two programs. Kid Care CHIP is also working with the EqualityCare office to review denial and closure reports from DFS to ensure that the program is receiving all applications sent to the program.

- *How many parents of children in the program report having health insurance?* The "KIDS" system collects data on each individual on the application. If a parent indicates on their application that they do have health insurance for themselves, that data is entered into the system. However, there are no requirements for a parent to release whether they have insurance – they are only required to notify the program if the child has insurance.

  Kid Care CHIP is working to create a report for this information; however, with the waiver for parents pending, it has not been created as of this date.

- Within chapter three *(page 20, paragraph 2)* it is asserted that some of the Kid Care CHIP reports have been problematic and some information was not as useful as it could be. The evaluation team reviewed many reports including data sent in text files to Blue Cross Blue Shield of Wyoming, applications, Access databases, Excel spreadsheets and data reports from the system. Kid Care CHIP believes there were issues regarding the data systems. In the future, Kid Care CHIP will collaborate with the evaluation team to establish a united data analysis to provide the necessary reports and information.

- The report states *(page 22, paragraph 1)* that throughout its history, Kid Care CHIP has underspent both its federal allotment and state funds. It also states that "...funds have been available to develop additional reports to support analysis and problem solving." Although the program has underspent its federal and state funds, due to program restrictions, the Department could not allocate more funds to data enhancements than it had in the previous four years.

APPENDICES

Kid Care CHIP: Wyoming's State Children's Health Insurance Program

APPENDIX A

Selected statutes

TITLE 35 – PUBLIC HEALTH AND SAFETY

CHAPTER 25 – CHILD HEALTH INSURANCE PROGRAM

35-25-101. Uninsured child health insurance program.

There is created a child health insurance program for families with a gross monthly income at or below one hundred eighty-five percent (185%) of the federal poverty level, until July 1, 2005, and thereafter, for families with a gross monthly income at or below two hundred percent (200%) of the federal poverty level.

35-25-102. Definitions.

(a) As used in this act:

(i) "Child" means a person who has not yet reached the nineteenth anniversary of his birth;

(ii) "Department" means the department of health;

(iii) "Federal poverty level" means the federal poverty guideline updated annually in the federal register by the United States department of health and human services under the authority of section 673(2) of the Omnibus Budget Reconciliation Act of 1981;

(iv) "Private health insurance" means an individual insurance policy or contract for the purpose of paying for or reimbursing the cost of hospital and medical care;

(v) "State plan" means the state plan required by Public Law 105-33 to be submitted by the state to the United States secretary of health and human services to receive federal funding for a child health insurance program;

(vi) "This act" means W.S. 35-25-101 through 35-25-108.

35-25-103. Child health insurance program eligibility.

Subject to approval of the state plan by the United States secretary of health and human services, and subject to available state and federal funding the department shall provide a health insurance plan offered through a private insurance company licensed by the insurance commissioner to write insurance in Wyoming for an eligible child whose monthly gross family income is not more than one hundred eighty-five percent (185%)

of the federal poverty level, until July 1, 2005, and thereafter, whose monthly gross family income is not more than two hundred percent (200%) of the federal poverty level. A child who is determined eligible to receive benefits under this section shall remain eligible for twelve (12) months as long as the child resides in the state of Wyoming and has not yet attained nineteen (19) years of age. A child's eligibility to receive benefits under this act shall be redetermined on an annual basis. A simplified application process, which includes minimum eligibility requirements, shall be provided throughout the state at various public and private establishments approved by the department of health. To be determined eligible to receive benefits under this section, a child shall not be eligible under the Wyoming Medical Assistance and Services Act, shall not have been covered under another health insurance plan for a minimum of one (1) month prior to application for coverage under this act or, upon birth, the child would not otherwise be covered by a public or private health insurance plan. Eligibility under this section shall be determined by the department of health or its designee.

35-25-104. Private insurance program benefits.

A child eligible for services under this act shall receive benefits developed by the health benefits committee established under W.S. 35-25-105 that include cost sharing factors, not to exceed the maximum allowable under Public Law 105-33, exclusions and limitations. The benefit package shall include, at a minimum, inpatient and outpatient hospital services, physician services, laboratory and x-ray services, well-baby and well-child care including age appropriate immunizations and the additional services of prescription drug coverage, vision coverage and dental coverage which will include preventive and basic services developed by the health benefits committee.

35-25-105. Health benefits plan committee.

(a) A health benefits plan committee is hereby established and shall be composed of ten (10) members, which include:

(i) The director of the Wyoming department of health or his designee;

(ii) The director of the Wyoming department of family services or his designee;

(iii) The Wyoming insurance commissioner or his designee;

(iv) One (1) representative each, appointed by the governor, consisting of:

(A) An authorized insurer writing individual and group health insurance business in Wyoming;

(B) An employer;

(C) A parent;

(D) A licensed insurance agent experienced in selling health insurance;

(E) A licensed physician who specializes in pediatric care or family medicine;

(F) A licensed health care provider experienced in providing pediatric care; and

(G) A member of the general public.

(b) The terms of the committee members appointed by the governor shall be four (4) years. Members of the committee appointed prior to July 1, 2003 may continue to serve the remainder of their terms. The committee shall review on at least a biennial basis the form and level of benefits to be made available pursuant W.S. 35-25-104.

(c) The committee shall develop a package of benefits as allowed by section 2103(a)(4) of Public Law 105-33, including cost sharing factors, exclusions and limitations.

(d) The committee shall submit its recommendations to the director of the department for approval no later than October 1, 2003, and at least biennially thereafter.

(e) Members of the committee shall be reimbursed for travel and per diem in the same manner as state employees. Members may also be reimbursed for any committee-related expenses which receive prior approval by the department. Members shall not be otherwise compensated for their services.

(f) Committee meetings shall be open to the public.

35-25-106. Private health insurance plan request for proposals.

(a) The department shall publish notice of a request for proposals from qualified insurers to provide a health insurance plan for children insured under W.S. 35-25-103 of this act. The department shall award the contract for this service to an insurer based on price, the provision of benchmark services determined pursuant to W.S. 35-25-105(c), and other factors listed in the department's request. The contract for health insurance awarded under this section shall contain provisions with respect to exclusions from coverage for preexisting conditions that are no more restrictive than those described in section 2102 (b)(1)(B)(ii) of Public Law 105-33. The contract shall include provisions for changes in terms and conditions and for rebidding in case major changes are needed. The department shall have the right to rebid the contract after two (2) years.

(b) Biennially, the department may allow the contractor to adjust the price charged for the coverage, but if the price is increased, the department may, after public notice, rebid the contract.

(c) If the department does not receive a proposal from an insurance company within one hundred twenty (120) days after issuing the request for proposals required in subsection

(a) of this section, the department may provide services to children eligible under this act with a public health benefit package designed to provide the same services as authorized under the Wyoming Medical Assistance and Services Act. A medical provider who accepts payment for services provided under this subsection shall not charge or attempt to collect payments in excess of the rate schedule established by the department of health.

35-25-107. Program expenditures; monitoring; recommendations; required action to limit expenditures to budget available.

(a) The department shall project monthly expenditures under this act each month through the end of the biennium based upon the level of activity for the previous months and the trend in expenditures compared to previous expenditures. If the projections indicate that expenditures may exceed the federal and state funds available under this act, the department, may, by rule and regulation and subject to availability of funds, limit participation in the program under this section as follows:

(i) The department may impose a partial or total moratorium on new enrollments in the programs under this act until funds are available to meet the needs of new enrollees;

(ii) For current recipients of benefits under this act, priority for the continuation of funding shall be given to those families with the lowest incomes.

(b) In the last six (6) months of the biennium, the department shall include a projection of expenditures for the next biennium based on the spending for the current biennium unless the legislature provides for a different level of funding for the next biennium.

(c) The funding for the child health insurance program shall be deemed to be included within the community and family health division line item within the department of health budget unless a separate line item is provided in the budget bill. General fund expenditures for the child health program shall not exceed the amount needed to match federal funds without explicit authorization enacted in the budget bill.

35-25-108. Implementation; duties; restrictions on the department of health.

(a) The department shall:

(i) Administer this act within the fiscal constraints of Public Law 105-33 and subsequent federal enactments governing this program and the state budget as enacted by the legislature;

(ii) Develop a state plan for child health insurance to qualified recipients under this act and otherwise provide for the effective administration of this act;

(iii) Maintain records on the administration of this act and report to the federal government as required by federal law and regulation;

(iv) Adopt, amend and rescind rules and regulations on the administration of this act following notice and public hearing in accordance with the Wyoming Administrative Procedure Act;

(v) Establish indicators for measuring access, process, quality and outcomes effectiveness in improving children's health.

(b) The department shall not implement:

(i) The program under this act until a state plan has been approved by the United States secretary of health and human services; and

(ii) Any state plan that does not conform to the requirements of this act.

35-25-109. Repealed By Laws 2003, Ch. 99, 2.

35-25-110. Repealed By Laws 2003, Ch. 99, 2.

35-25-111. Participation of parents or guardians; employer premium contribution.

(a) Subject to the approval of a waiver by the United States secretary of health and human services and subject to available state and federal funding, parents or guardians of children enrolled in the child health insurance program or the medical assistance program may be eligible for participation in the programs under the following conditions:

(i) One (1) of the parents or guardians in the household is working at a full or part-time job;

(ii) If the parents are separated or divorced, the noncustodial parent shall not be eligible for participation in the program;

(iii) The employer of the participating parent or guardian agrees to pay for at least one-half (1/2) of the monthly premiums of the health insurance plan selected by the parent or guardian under the provisions of subsection (b) of this section. For program participants who work less than an average of thirty (30) hours per week, the department may waive this provision and collect an hourly fee from the employer.

(b) Parents or guardians may participate in the program through the employer's health insurance plan or through a group plan contracted by the department for program participants under the provisions of W.S. 35-25-106(a). The department shall assess the

qualifying parents and guardians a participation fee. The amount of the fee may vary depending upon the level of income greater than one hundred thirty-three percent (133%) of the federal poverty level. Parents or guardians with a household income of one hundred thirty-three percent (133%) of the federal poverty level or less shall not be assessed a participation fee.

(c) If an employer of a parent or guardian refuses to participate in the program, the parent or guardian who would otherwise qualify for the program under subsection (b) of this section may participate in the program by paying the employer's share of the premium as determined pursuant to paragraph (a)(iii) of this section. The funds from the parent or guardian may come from a health savings account, a third party or another source.

(d) In the group plan offered by the department, the package of benefits available to participating parents and guardians may vary depending upon qualifying household income. The plan offered by an employer is not subject to a benchmark set of benefits.

(e) If the parent or guardian is covered through an employer's group health insurance plan, the total amount of funding provided to the parent or guardian to participate in the employer's plan shall not exceed the cost that the department would pay for participation in the plan provided under W.S. 35-25-106(a), as adjusted for parents, minus the employer's contribution under paragraph (a)(iii) of this section and the employee's contribution under subsection (b) of this section.

(f) Students who are attending the University of Wyoming or a state community college shall not be disqualified pursuant to paragraph (a)(i) of this section provided they qualify under the work-study provisions of the temporary assistance to needy families program.

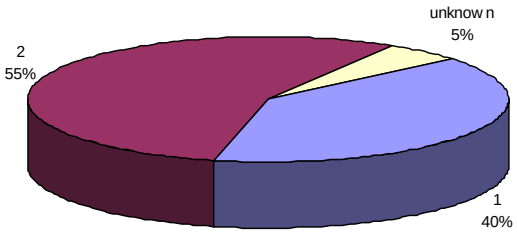
(g) The total enrollment of parents, guardians and students through the waiver in the child health insurance program or the medical assistance program shall not exceed three thousand seven hundred twenty (3,720) for the 2007-2008 biennium and the total enrollment for future biennia shall be as determined in the applicable budget bill.

APPENDIX B

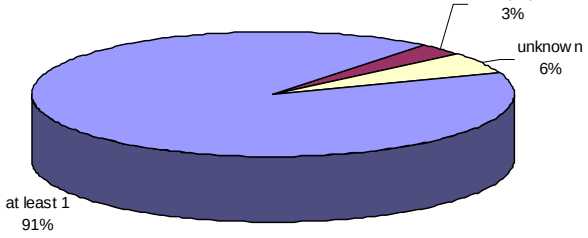
Program descriptive statistics

January '07 Kid Care CHIP enrollees by selected household characteristics

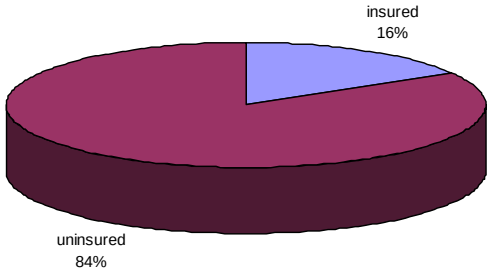
B.1
Percent of enrollees by number of adults in household



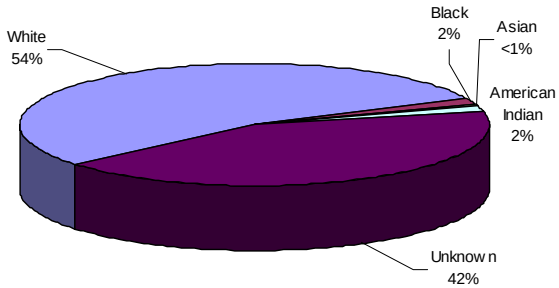
B.2
Percent of enrolles with employed parents



B.3
Percent of employed parents with insurance



B. 4
Percent of enrollees by race

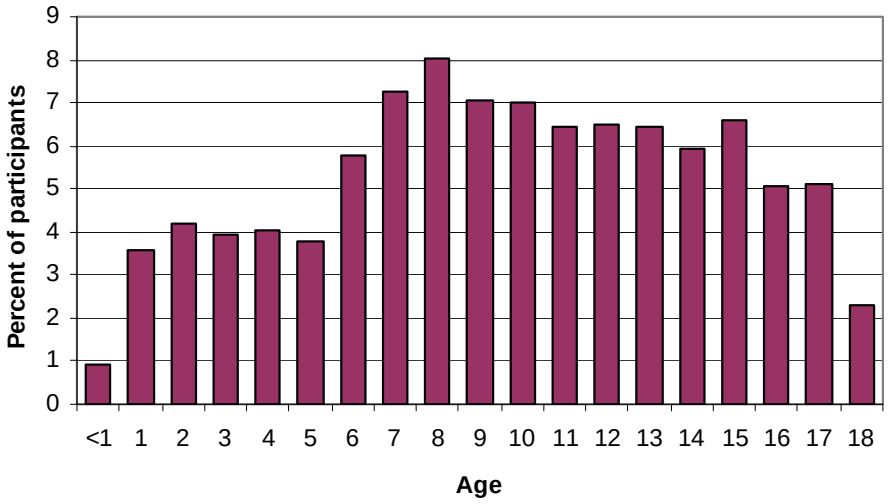


Source: LSO review of January '07 applications and enrollment documentation

February '07 Kid Care CHIP participants by selected characteristics

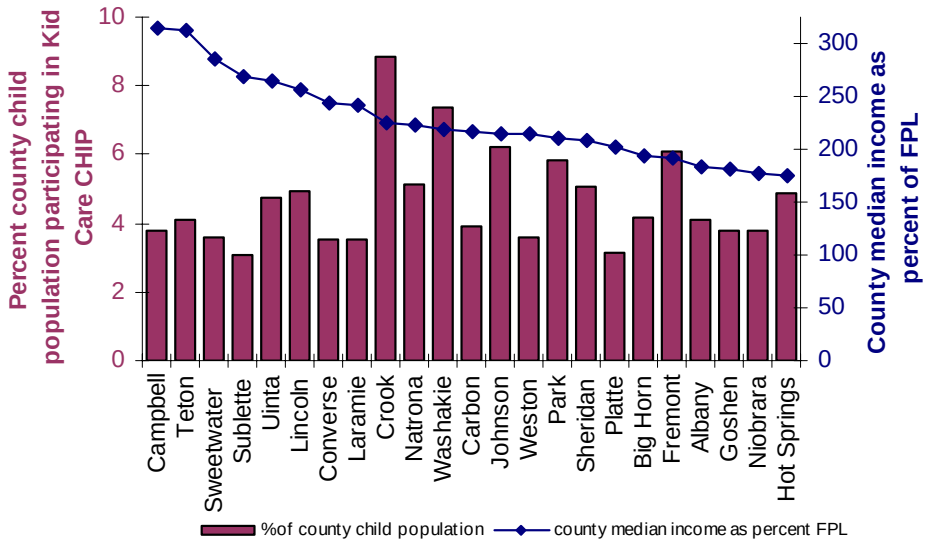
B.5

Kid Care CHIP participants by age



B.6

Comparison of Kid Care CHIP participation to county median income



Source: Kid Care CHIP list of enrollees as of February '07

APPENDIX C

2007 Federal poverty limits

2007 Poverty Guidelines
April 1, 2007 – March 31, 2008

Number in family	Percent of Federal Poverty Level				
	100%	150%	200%	250%	300%
1	$10,210	$15,315	$20,420	$25,525	$30,630
2	13,690	20,535	27,380	34,225	41,070
3	17,170	25,755	34,340	42,925	51,510
4	20,650	30,975	41,300	51,625	61,950
5	24,130	36,195	48,260	60,325	72,390
6	27,610	41,415	55,220	69,025	82,830
7	31,090	46,635	62,180	77,725	93,270
8	34,570	51,855	69,140	86,425	103,710

State income eligibility limits, as of July 2006

Nine states have eligibility below 200 percent FPL: Alaska, Idaho, Montana, Nebraska, North Dakota, Oklahoma, Oregon, South Carolina, and Wisconsin

Twenty-five states have eligibility at 200 percent FPL: Alabama, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Nevada, North Carolina, Ohio, Pennsylvania, South Dakota, Texas, Utah, Virginia, and Wyoming

Sixteen states have eligibility above 200 percent FPL: California, Connecticut, Georgia, Hawaii, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, Vermont, Washington, and West Virginia

APPENDIX D

Kid Care CHIP benefits package

As of February 2007, the benefits for Kid Care CHIP enrollees are as follows:

Kid Care CHIP
Wyoming's Choice for Healthy Kids

The lifetime maximum benefit per insured person is $1 million.
If a child is removed from the program and at a later date reapplies for the program and is found eligible, the child's lifetime maximum will start over.

Kid Care CHIP Benefits:
Inpatient Hospital Benefits: ✓ Semi private room; intensive and coronary care units; general nursing; drugs; oxygen; blood transfusions; laboratory; imaging services; physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms; routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered. ✓ Coverage of postpartum care for at least forty-eight hours for vaginal delivery and ninety-six hours for caesarean section is guaranteed. Any decision to shorten the length of inpatient stay to less than these stated amounts shall be made by the attending provider and the mother.
Outpatient benefits: ✓ All benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including but not limited to observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness are covered.
Physician benefits (including Clinic Benefits): ✓ Office, clinic, home, outpatient surgery center and hospital treatment for a medical condition, injury or illness by a physician, mid-level practitioner or other covered provider are covered. ✓ Well child, well baby and immunization services as recommended by the American Academy of Pediatrics are covered. ✓ Routine physicals for sports, employment or as required by a government authority are covered. ✓ Anesthesia services rendered by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered provided that surgical and/or hospital services are also covered.
Surgical benefits: ✓ Covered as described in inpatient and outpatient hospital and physician benefit descriptions. In addition professional services rendered by a physician, surgeon or doctor of dental surgery for treatment of a fractured jaw or other injury to sound natural teeth and gums are covered.

Prescription drugs:

- ✓ Coverage includes drugs prescribed by a practitioner acting within the scope of his practice. Chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines, prenatal vitamins, and drugs needed after an organ or tissue transplant are covered.
- ✓ The contractor may use a Medicaid formulary if it chooses to employ a formulary.
- ✓ Prescribed diabetic supplies including insulin, test tape, syringes, needles and lancets are covered as a prescription drug.
- ✓ Food supplements and vitamins **are not covered** with the exception of prenatal vitamins and medical foods for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exists. The need for a prescription to obtain a food supplement or vitamin shall not affect the application of this provision.

Laboratory and radiological benefits:

- ✓ Coverage includes imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness or medical condition that are not described elsewhere in this section.
- ✓ X-ray, radium or radioactive isotope therapy

Prenatal care and pre-pregnancy family planning benefits and prescribed supplies:

- ✓ Prenatal care is covered as described for other medical conditions in this section. Pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives.

Inpatient Mental Health benefits:

First Level of Benefits:

- ✓ Services furnished in a hospital, including a state-operated mental hospital; a residential or other 24-hour therapeutically planned structural service; or a partial hospitalization program are covered. Twenty-one days of inpatient mental health benefits are covered per benefit year. Partial hospitalization benefits may be exchanged for inpatient days at a rate of one inpatient day for two partial treatment days. A partial hospitalization program that is operated by a hospital shall comply with the standards for a partial hospitalization program that are published by the American Association for Partial Hospitalization.
- ✓ The following specific limitations apply to coverage depending upon the child's diagnosis and the treatment setting. Federal law prohibits coverage of a child in a facility which would be termed an institute for mental disease (IMD) under Medicaid regulations (42 CFR 435.1009). A child who has applied for or been found eligible for the CHIP program prior to becoming a patient in an IMD will be covered by the CHIP program within the individual benefit limits specified in this section. However, a child who is a patient in an institution for mental disease who did not apply for the CHIP program prior to admission is not eligible for the CHIP program until he or she is discharged from the IMD.
- ✓ No limits to inpatient mental health shall be imposed on children diagnosed with the following disorders as defined by the American Psychiatric Association:
- ✓ Schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, autism.

Second Level of Benefits:

- ✓ The second level of benefits provides for an additional nine (9) days of care, for a total of thirty (30) days per benefit year, with pre-approval and case management by Blue Cross Blue Shield of Wyoming (BCBSWY). BCBS will work closely with the provider to ensure treatment plans are in place and managed.

Outpatient mental health benefits:
First level of Benefits
- ✓ Professional outpatient mental health services up to a maximum of twenty visits per year are covered. The visits can be furnished in a variety of community based settings or in a mental hospital.
- ✓ Partial hospitalization benefits are paid as described in the inpatient mental health benefits section.
- ✓ No limits to outpatient mental health benefits shall be imposed on children diagnosed with the following disorders as defined by the American Psychiatric Assoc:

- ✓ Schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, autism

Second Level of Benefits:

- ✓ The second level of benefits provides for an additional twenty (20) outpatient visits per benefit year, for a total of forty (40) days per benefit year, with pre-approval and case management by Blue Cross Blue Shield of Wyoming (BCBSWY). BCBS will work closely with the provider to ensure treatment plans are in place and managed. Providers will have the capability to bill for partial (30 minutes or less) and full (more than 30 minutes) sessions. This capability only applies to the second level of benefits.

Inpatient substance abuse treatment benefits and residential substance abuse treatment benefits:
- ✓ The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 in a 12-month period, until a lifetime inpatient maximum benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the lifetime limits.

Outpatient substance abuse treatment benefits:
- ✓ The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 in a 12 month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the lifetime limits.

Vision benefits and medical eye care:
- ✓ Services for the medical treatment of diseases or injury to the eye by a licensed physician or optometrist working within the scope of his/her license are covered.
- ✓ One exam every 12 months, one pair of lenses every 12 months (except in the case of a change in prescription) and one set of frames every 12 months. Frames are limited to $100 per frame. (If the cost of the frame is more than $100 families will be responsible for any additional cost)

Audiological benefits:
- ✓ Hearing exams, including newborn hearing screens in a hospital or outpatient setting are covered. Coverage includes assessment and diagnosis.
- ✓ Hearing aides are not covered.

Abortion:
- ✓ Only abortions which are necessary to save the life of the mother or to terminate pregnancy, which is a result of rape or incest are covered.

Diabetes education:
- ✓ Coverage for medically necessary and prescribed outpatient self-management and education for treatment of diabetes.

Rehabilitation:
- ✓ Covered with a $25,000 lifetime benefit.

Spinal Manipulation:
- ✓ Covered with a $250 maximum per year.

Physical, Speech and Occupational Therapy

✓ Covered up to $750 per year
Ground and Air ambulance is covered in the event of an emergency
The contractor shall cover medically appropriate second opinions which may include major diagnoses or courses of treatment
Dental benefits: ✓ Exams – once in a six month period not to exceed two in one year ✓ Bitewing x-rays – once in a six month period, not to exceed two in one year ✓ Full mouth x-rays – once in a thirty six month period ✓ Prophylaxis (cleanings) – once in a six month period, not to exceed two in one year ✓ Topical Fluoride applications – once in a twelve month period ✓ Space maintainers to maintain space of primary (baby) teeth – once in a three year period ✓ Sealants on posterior (back) permanent teeth – once in a three year period ✓ Simple extractions ✓ Emergency treatment for the relief of pain ✓ Amalgam restorations (silver fillings) on back teeth and Synthetic restorations (white fillings) on front teeth ✓ Sedation for children up to the age of 8 years old ✓ Full mouth debridement for children age 13-18 years old ✓ Root canals and pulpotomy's ✓ Stainless steel crowns ✓ Gold or porcelain crowns for children age 16-18 years ✓ Partial dentures for children missing front teeth for ages 16-18 years. **Annual maximum is $1,000 per benefit year.**
Benefits if provided by an out of state doctor are only available if it is due to a referral from a network provider in Wyoming

Kid Care CHIP Non Covered Services

In addition to any exclusions noted in the individual coverage descriptions, the following services need not be considered covered benefits under the contract.
✓ Experimental services or services generally regarded by the medical profession as unacceptable treatment.
✓ Custodial Care.
✓ Personal comfort/hygiene/convenience items, which are not primarily medical in nature.
✓ Organ and tissue transplants
✓ TMJ treatment
✓ Whirlpools
✓ Treatment for Obesity
✓ Acupuncture
✓ Biofeedback
✓ Chiropractic services
✓ Cosmetic surgery
✓ Radial keratotomy
✓ Private duty nursing
✓ Treatment for which other coverage such as worker's compensation is responsible.
✓ Routine foot care
✓ Administrative transportation
✓ Contact Lenses
✓ Orthodontia
✓ For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of any form, or charges for medical information
✓ For inpatient admissions which are primarily for diagnostic studies or primarily for physical therapy
✓ For custodial care, domiciliary care or rest cures or treatment in a facility, or part of a facility, that is mainly a place for: (a) rest; (b) convalescence or (c) custodial care
✓ For screening examinations, except as provided for wellness benefits under this program
✓ For radial keratotomy, myoptic keratimileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia,hyperopia, or stigmatic error
✓ For therapeutic or elective termination of pregnancy prior to full term
✓ For complications or side effects arising from services, procedures, or treatments excluded
✓ Durable Medical Equipment
✓ Hearing Aides
✓ For private duty nursing
The following services shall not be considered covered benefits under the contract. The contractor is prohibited from offering any of the following benefits:
In vitro fertilization, gamete or zygote intra fallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, fertility enhancing treatment beyond diagnosis.
Benefits for a child incarcerated in a criminal justice institution. The child is excluded from coverage only if he/she meets the definition of an inmate of a public institution as defined at 42 CFR 435.1009
Any treatment that is not medically necessary.

Recent Program Evaluations

Community College Governance	May 1999
Child Protective Services	November 1999
Wyoming State Archives	May 2000
Turnover and Retention in Four Occupations	May 2000
Placement of Deferred Compensation	October 2000
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State Park Fees	May 2001
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Wyoming Aeronautics Commission	May 2002
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Workers' Compensation Claims Processing	June 2003
Developmental Disabilities Division Adult Waiver Program	January 2004
Court-Ordered Placements at Residential Treatment Centers	November 2004
Wyoming Business Council	June 2005
Foster Care	September 2005
State-Level Education Governance	December 2005
HB 59: Substance Abuse Planning and Accountability	January 2006
Market Pay	July 2006
Drug Courts	July 2006
A&I HRD Role in State Hiring	December 2006

Evaluation reports can be obtained from:

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213 State Capitol Building Cheyenne, Wyoming 82002
Telephone: 307-777-7881 Fax: 307-777-5466
Website: http://legisweb.state.wy.us