Chapter 11: HealthWave

Executive Summary

Description

HealthWave is a managed care program through which two populations, HealthWave Title XIX (traditional Medicaid) and HealthWave Title XXI (State Children's Health Insurance Program [SCHIP]) receive health care services. Approximately 75% of HealthWave participants are in Title XIX component. Although there are subtle differences in coverage, the HealthWave program is seamless to beneficiaries. Prior to January 1, 2007, HealthWave was managed by a single managed care organization (MCO). The HealthWave program now provides capitated managed care through two MCOs: Children's Mercy Family Health Partners (CMFHP) and UniCare. Mental health services, however, are carved out from physical health services. Medicaid beneficiaries are primarily covered through a Prepaid Ambulatory Health Plan (Kansas Health Solutions) and a Prepaid Inpatient Health Plan (Value Options). Mental health services for SCHIP are covered by Cenpatico, a private MCO providing separately capitated services. Some HealthWave services are still provided through fee-for-service (FFS). For example, dental services, previously provided through a capitated contract, are now fee-for-service.

Analysis

HealthWave XIX enrollment and expenditures increased in 2007 primarily because approximately 50,000 beneficiaries were shifted from the HealthConnect Kansas program to HealthWave. Simultaneously, the Deficit Reduction Act of 2005 (DRA) had a negative affect on Medicaid enrollment due to the paperwork backlog created by the citizenship documentation requirements. This resulted in a year-long decline of 20,000 members. HealthWave also experienced a cost savings through the competitive bidding process that resulted in new HealthWave contracts with CMFHP and Unicare. From state fiscal year (FY) 2004 through FY 2006, average expenditures per member increased. However, a downward trend began in FY 2007.

Key Points

- By contract and federal obligation, the Kansas Health Policy Authority (KHPA) collects a wide range of quality and performance data on the HealthWave program. However, this information has not yet been made public, leaving consumers with little information to select their MCO, and leaving state policymakers without a strong basis for program policy decisions.

- In FY 2009, KHPA expects a reduction of approximately 1% in capitation rates due to formula-driven actuarial adjustments. There are also potential federal funding issues in light of Congress' failure to reauthorize SCHIP. Federal funding availability for increased participation of

uninsured eligible children in Kansas' HealthWave XXI program is uncertain, even at the current threshold of 200% Federal Poverty Level (FPL).

- Senate Bill 81 (2008) authorizes an expansion of the SCHIP program up to 250% of the FPL for children 0-18, if federal funding becomes available. However, in FY 2009, federal funding for SCHIP expansion is not expected to become available. KHPA plans to expand the SCHIP program through HealthWave as instructed by Senate Bill 81 when federal funding is assured.

Recommendation

- Make performance and quality data available for consumers, policymakers and other stakeholders in FY 2009 in order to assist in beneficiary plan selection and inform program policy changes.

Overview and Background

Program Description

The HealthWave program of capitated managed care was developed to provide comprehensive health coverage for low income children and families across the state of Kansas. This care is offered through a combination of fee-for-service (FFS) coverage and direct contracts with two physical health managed care organizations (MCOs), Children's Mercy Family Health Partners (CMFHP) and UniCare Health Plan of Kansas (UniCare) and one mental health managed care organization, Cenpatico Behavioral Health (CBH). These companies join with the Kansas Health Policy Authority (KHPA) to provide children and families a health care delivery system of high quality care with comprehensive coverage that promotes healthy choices for members.

HealthWave provides access to health care for two populations: HealthWave XIX and HealthWave XXI. Although there are subtle differences in coverage, the HealthWave program is seamless to beneficiaries. This is an attribute that is important for enrollees who transition from one population to the other and for families with children enrolled in both HealthWave XIX and HealthWave XXI.

Prior to January 1, 2007, a single HealthWave XIX MCO, FirstGuard Health Plan of Kansas, was offered as the managed care choice to Medicaid members in 62 counties. Within these counties, Medicaid members could choose between FirstGuard and HealthConnect Kansas (HCK), a FFS program.

Following a year long recontracting process in 2006, HealthWave contracts were awarded to CMFHP and UniCare as the managed care organization for "physical health", effective January 1, 2007. The physical health MCOs are required to provide coverage equal to or greater than the Medicaid FFS program. Mental health coverage for all HealthWave XXI members is provided by Cenpatico Behavioral Health (CBH). The mental health coverage provided by CBH is equivalent to the State Employee Health Plan and adds Community Psychiatric Supportive Treatment and Psychosocial Rehabilitation Group Therapy as value added services. Dental services for both HealthWave XIX and XXI members are reimbursed by FFS and provide full scope coverage for children in both populations and emergent dental care for adults. The majority of Medicaid beneficiaries, including all HealthWave XIX members, receive mental health care from Kansas Health Solutions (KHS) through the Prepaid Ambulatory Health Plan (PAHP) and substance abuse care from Value

Options (VO) through the Prepaid Inpatient Health Plan (PIHP). Table 1 provides a condensed version of coverage responsibilities.

Table 1
Programs and Benefits for HealthWave Families

Type of Service	*Health Plan (Medical)*	*Benefits Coverage*	*Method of Payment*
Physical Health Services (Medical)	Children's Mercy Family Health Partners	HW XIX and XXI equivalent to Medicaid FFS	Risk Based Capitation
	UniCare Health Plan of Kansas	HW XIX and XXI equivalent to Medicaid FFS	Risk Based Capitation
Dental	Kansas Medicaid Program (EDS)	HW XIX and XXI receive identical coverage	FFS
Mental Health HealthWave XXI	Cenpatico Behavioral Health	Equivalent to the State Employee Health Plan plus two value added services	Risk Based Capitation
Mental Health HealthWave XIX	Kansas Health Solutions	SRS-contracted list of covered services	Non-Risk Capitation
Substance Abuse HealthWave XIX	Value Options	SRS-contracted list of covered services	Risk Based Capitation

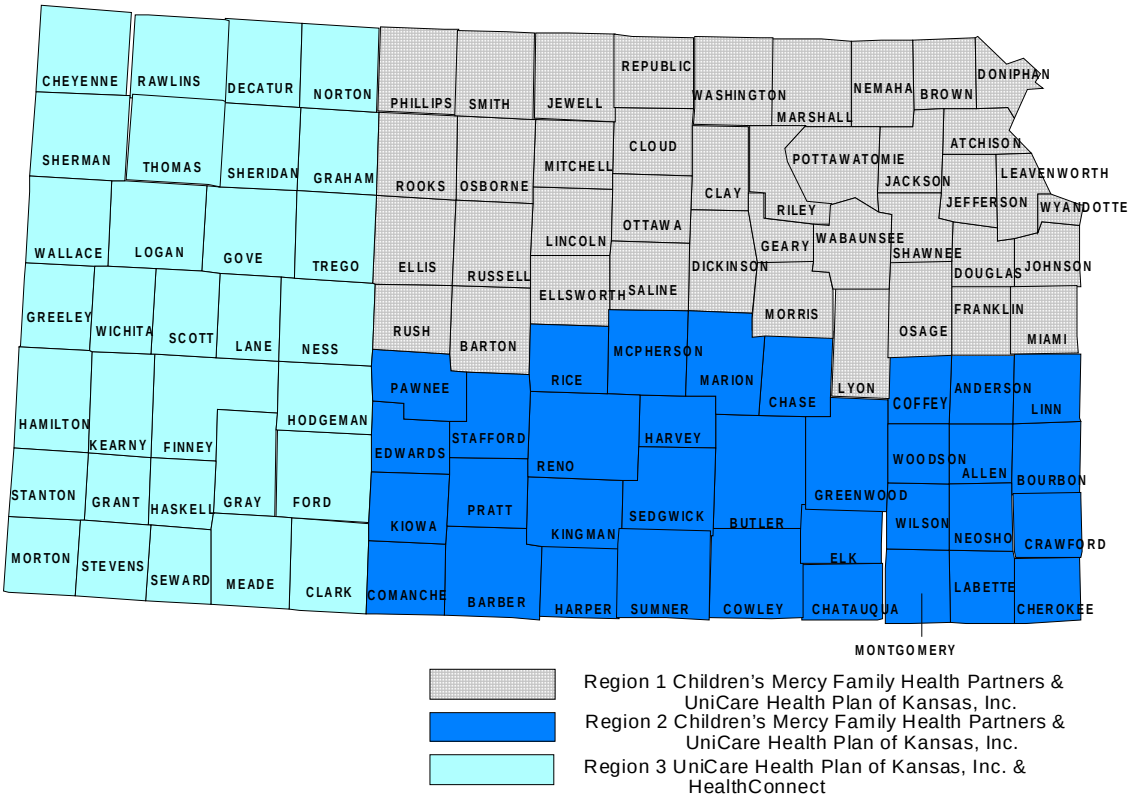
With the successful re-contracting for HealthWave MCOs in 2006, the program grew from a single MCO, FirstGuard, to two MCOs, CMFHP and UniCare. Because beneficiaries now have a choice between the two HealthWave MCOs in the two regions representing 94.7% of the HealthWave population, beneficiaries in these two regions no longer have the option of enrolling in the largely unmanaged HealthConnect program, which serves members through the FFS Medicaid program. [Note: Federal rules require that beneficiaries faced with a managed care option must be given a choice of plans.]

Enrollment in the HealthWave program increased in January 2007 by about 60,000 as these individuals and families were transferred from the HealthConnect program. Table 3 documents the increase in HealthWave participation. Each of the Medicaid FFS programs, such as acute care hospitals or prescription drugs, will show a corresponding decline in both participants and expenditures in 2007, a dynamic noted in the 2008 reviews of the programs.

Service Regions

To facilitate the implementation of HealthWave throughout Kansas, the state was divided into three distinct service regions. Identified in Illustration 1 are these service regions as well as the managed care plans active in each region.

Figure 1



HealthWave XIX and XXI members in Regions 1 and 2 choose between CMFHP and UniCare. HealthWave XIX members in Region 3 choose between UniCare and HealthConnect Kansas. HealthWave XXI members in Region 3 are assigned to UniCare.

Population Distribution by Program and Plan

In the year following the contract-related expansion of the HealthWave population in January 2007, HealthWave XIX increased its enrollment by another 8.7% while HealthWave XXI experienced 9.2% growth. HealthConnect Kansas remained level. The growth experienced in HealthWave is directly related to the increase in staff and resources at the HealthWave Clearinghouse. KHPA received the resources necessary to reduce enrollment barriers created by federal legislation implemented in FY 2007, which required applicants to document both their citizenship and identity. Those efficiencies included:

- Developing a link with the Department of Vital Statistics to verify Kansas births.
- Streamlining imaging processes to allow for quick dissemination of materials with the eligibility clearinghouse.
- Determining appropriate staffing levels and increasing staff to deal with the backlog of applications and to maintain established standards for processing time.

Figure 2 and Table 2 are representations of the HealthWave and HealthConnect Kansas (HCK) population distribution by quarter and indicate the majority of membership has chosen CMFHP as the MCO through which they receive care.

Figure 2

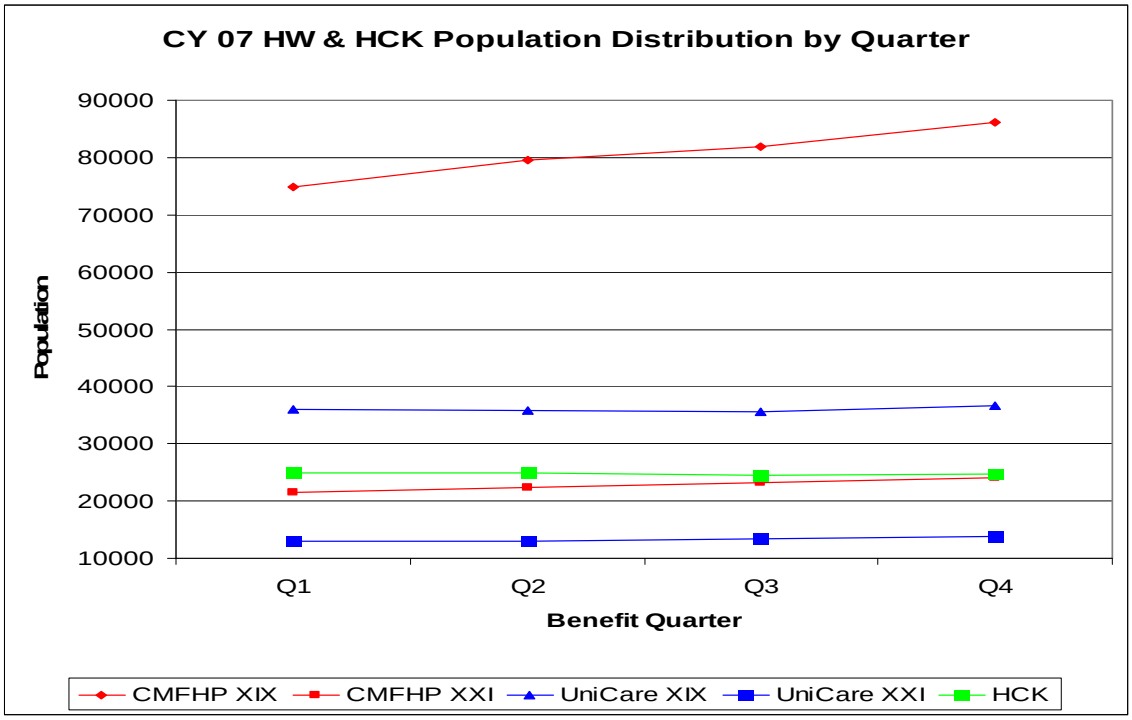


Table 2

Growth Rate Q1 - Q4 CY 2007	
Managed Care Plan	*Growth Rate*
CMFHP HW 19	14.95%
CMFHP HW 21	11.99%
UniCare HW 19	1.43%
UniCare HW 21	5.89%
HealthConnect Kansas	0.99%

Program Expenditures

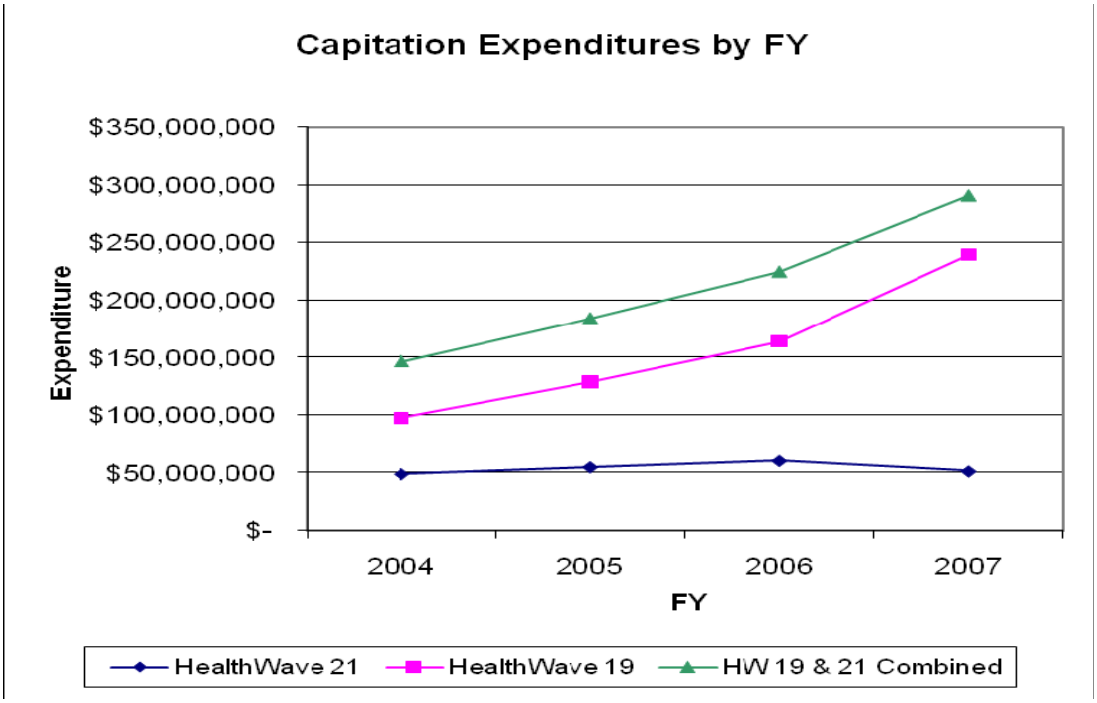
HealthWave accounts for approximately 27% of KHPA's annual combined Medicaid and SCHIP expenditures. These expenditures were calculated by combining reports from the Management and Administrative Reporting (MAR) system, a public report updated monthly and available on the Agency web site. Data in this section will illustrate a summary of overall HealthWave costs, focusing on the capitation and highest FFS expenditures for HealthWave members.

Capitation payments represent the total funds distributed to the MCOs. Payments are made to MCOs on a prospective, per-member per-month basis and are then used by the MCOs to compensate their medical providers for services delivered to Medicaid and SCHIP members. Capitation rates are based on the competitive bids provided by the health plans during the contracting process and updated each year to assure actuarial soundness and maintain approval by the federal government (CMS). HealthWave XIX experienced a cost savings in FY 2008 [not shown] as a result of the new contract with the two competing MCOs. The negotiated capitation rates were effec-

tive January 1, 2007.

Traditionally, capitation expenditures are the predominant expense for both HealthWave XIX and HealthWave XXI. Data collected for FY 2008 indicates capitation expenditures remain the largest cost drivers and are presently on target to reach KHPA's prediction by the end of FY 2008. Figure 3 indicates an upward trend from FY 2004 to FY 2007 for the overall HealthWave XIX expenditures.

Figure 3



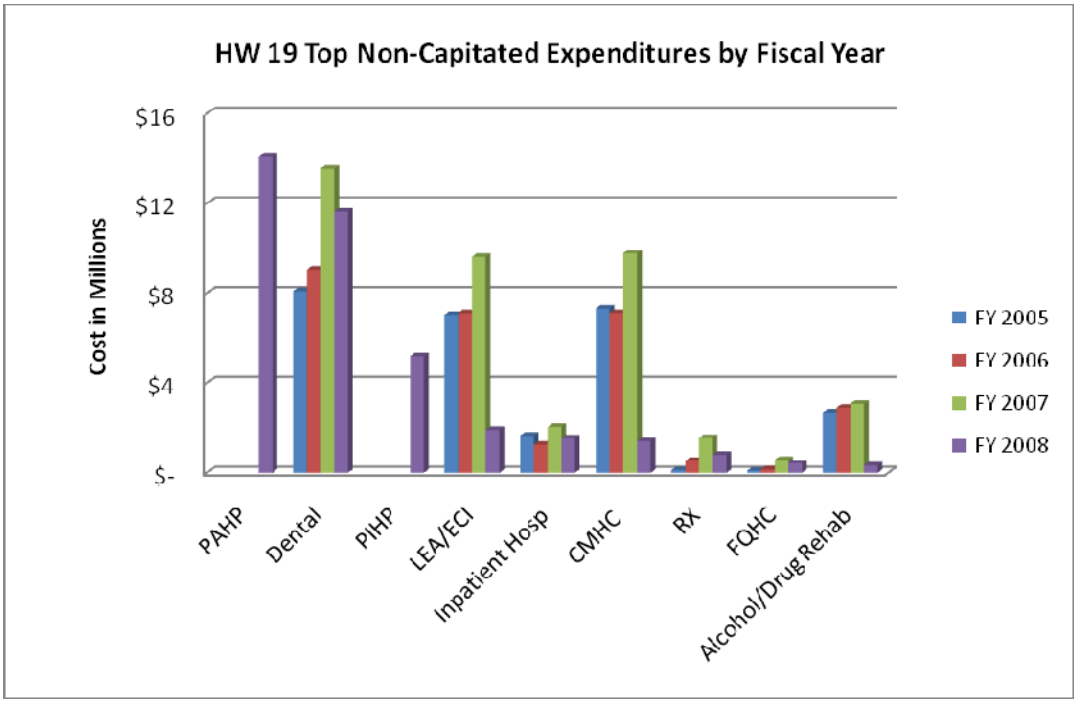
Non-capitated expenditures are those expenses that are covered benefits under HealthWave; however, they are carved out from the managed care plans. These charges are reimbursed directly to the provider on a fee-for-service basis. Examples of carve-out services include:

- Dental: All dental services are provided fee-for-service following a transition from a dental MC (Doral Health Plan) in July 2006.
- Mental Health
- Substance Abuse
- Local Education Agencies: Reimbursement for therapies and counseling provided to eligible students with individualized education plans has always been reimbursed FFS.
- In-patient hospital
- Prescription drugs

Figure 4 illustrates expenditures by "Category of Service" and those beneficiaries utilizing the specific benefits for FY 2005, 2006, 2007 and 2008 (projected). FY 2007 reflects the beginning of a major shift in several categories of service. First, there is an increase in MCO carved out pharmacy expenditures in 2007 directly relating to factor drugs prescribed for hemophiliacs as that population, which had been concentrated in the HealthConnect program, transitioned to HealthWave in 2007. Second, although incomplete, the FY 2008 data illustrates changes required by CMS to reform payments to Local Education Agencies (LEA). This reduces expenditures by approximately $8 million. Third, during FY 2008, Kansas Department of Social and Rehabilitation Services

(SRS) subsumed Alcohol/Drug Rehabilitation and Community Mental Health Care (CMHC) services for the majority of Medicaid beneficiaries. These services are now provided through the Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) respectively (see descriptions above). This change appears to have caused a net increase in HealthWave population expenditures. Both Figure 4 and Figure 5 exclude capitation payments made to the MCOs for regular (physical) health services.

Figure 4



*Please note, FY 2008 is not a full year's data. Expenditures by unique (unduplicated) beneficiaries.

Figure 5

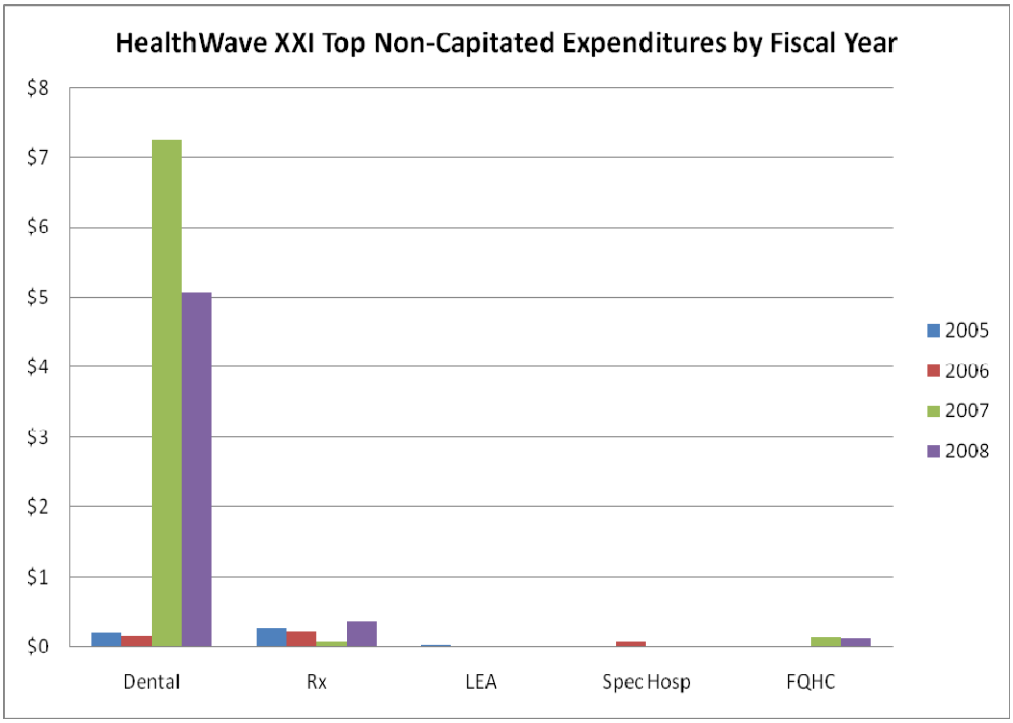


Figure 5 represents the top three expenditure categories for HealthWave XXI for FY 2005, 2006, 2007 and 2008. Prescription Drug costs increased even with fewer members utilizing these benefits. The cost increase is a result of growth in the use of factor drugs (used for treatment of patients with hemophilia). Payments outside of dental and factor drugs can be attributed to Presumptive XXI Eligibility. (Presumptive Eligibility is a process that allows low income uninsured children under the age of 19 access health care services from qualified providers while their formal HealthWave applications are being processed.)

Also of note, dental costs appear to drastically increase from FY 2006 to 2007 in both Title XIX and Title XXI. In actuality, this is a transfer of dental costs from a separate capitated contract with Doral Health Plan back into the fee-for-service dental program.

Tables 3 and 4 provide the total number of unduplicated enrollees and consumers of FFS services, as well as the average expense per consumer by category of service by year for HealthWave XIX and XXI (# Cons = number of consumers; Av Exp = average expense).

Table 3
Consumers and Average Yearly Expenditure in HealthWave XIX

	FY 2005		FY 2006		FY 2007		FY 2008*	
Category of Service	**# Cons**	**Av Exp**	**# Cons**	**Av Exp**	**# Cons**	**Av Exp**	**# Cons**	**Av Exp**
Managed Care Organizations	103,248	$1,249	117,840	$1,393	179,963	$1,331	171,145	$1,332*
PIHP (Substance Abuse)							169,664	$31
PAHP (Mental Health)							169,664	$83
Fee-for-service Dental	25,782	$314	29,467	$308	43,734	$310	43,172	$270
Fee-for-service CMHC	7,040	$1,041	7,245	$985	10,230	$956	3,679	$384
LEA/ECI	6,312	$1,116	6,529	$1,090	10,532	$914	4,204	$456
Fee-for-service Inpatient Hospital	428	$3,891	645	$1,951	504	$4,100	382	$4,020

Table 4
Consumers and Average Yearly Expenditures in HealthWave XXI

	FY 2005		FY 2006		FY 2007		FY 2008*	
Category of Service	**# Cons**	**Av Exp**	**# Cons**	**Av Exp**	**# Cons**	**Av Exp**	**# Cons**	**Av Exp**
Managed Care Organizations	52,198	$1,055	55,895	$1,085	54,928	$935	49,669	$695**
Fee-for-service Dental	863	$232	606	$246	22,781	$318	19,743	$257
Fee-for-service Prescribed Drugs	7	$39,385	2	$111,353	41	$1,998	5	$74,755***
FQHC					799	$170	911	$133

*The expenditures for FY 2008 do not represent a complete year.
**The higher average cost per consumer enrolled in HW 19 compared to HW 21 is due to pregnancy related costs.
***This average is based on utilization from members with hemophilia as factor drugs are reimbursed FFS for HW 21.

HealthWave Program Demographics

All figures in this section were developed from ad-hoc reports obtained through the Decision Support System (DSS). These figures contain demographics information for members in both HealthWave XIX and HealthWave XXI for FY 2007.

Figure 6

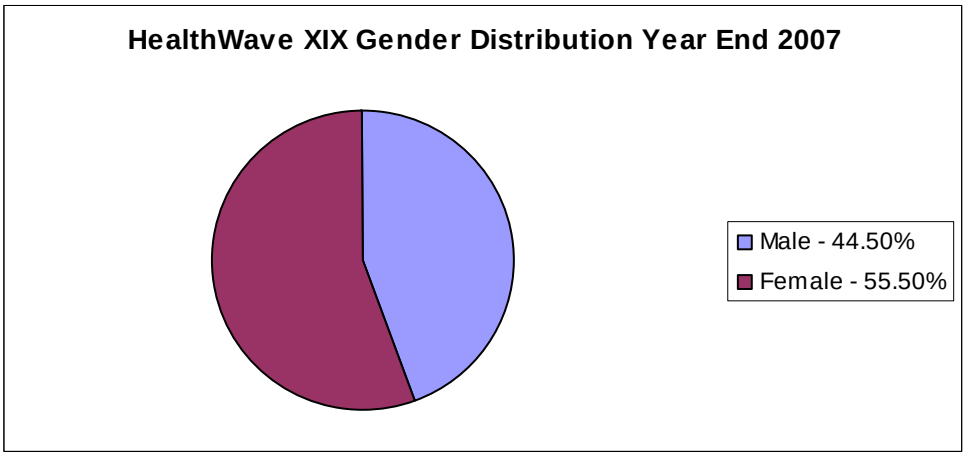
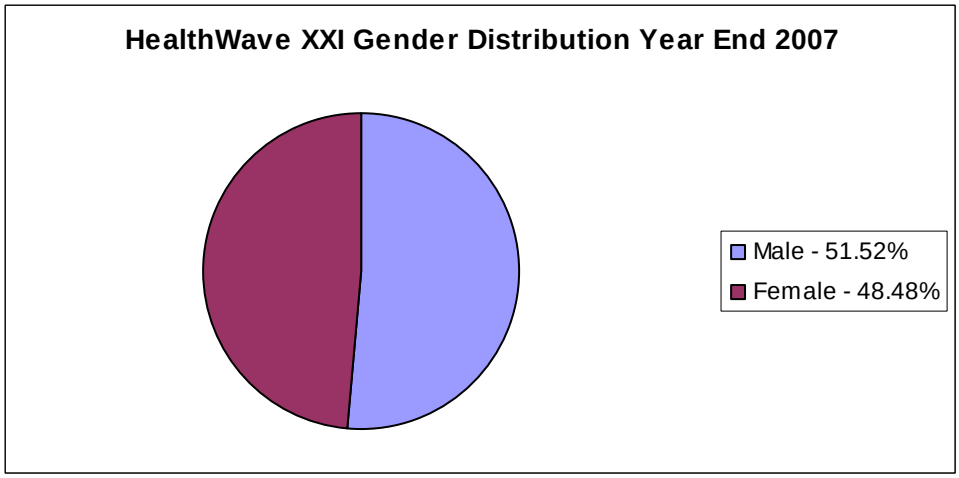


Figure 7



A comparison of beneficiary gender between HealthWave XIX and XXI reveals there are proportionally more females associated with HealthWave XIX. This variation is directly related to the number of pregnant women who are eligible for services under the HealthWave XIX program.

A comparison of race across HealthWave XIX and HealthWave XXI for FY 2005 to FY 2008 reveals a significantly larger percentage of Black or African-Americans in the HealthWave XIX compared to HealthWave XXI. This data depicts little change in the distribution of race over time for either program. HealthWave XIX experienced an increase in all populations from 2005 to 2008, with the exception of American Indians or Alaskan Natives, which remained very stable. The population percentages within HealthWave XXI remained stable in all categories.

Figure 8

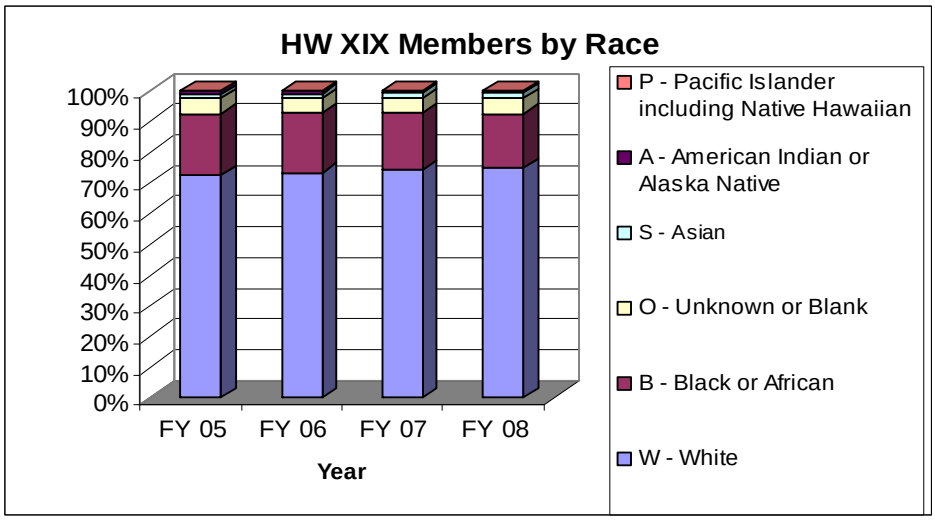


Figure 9

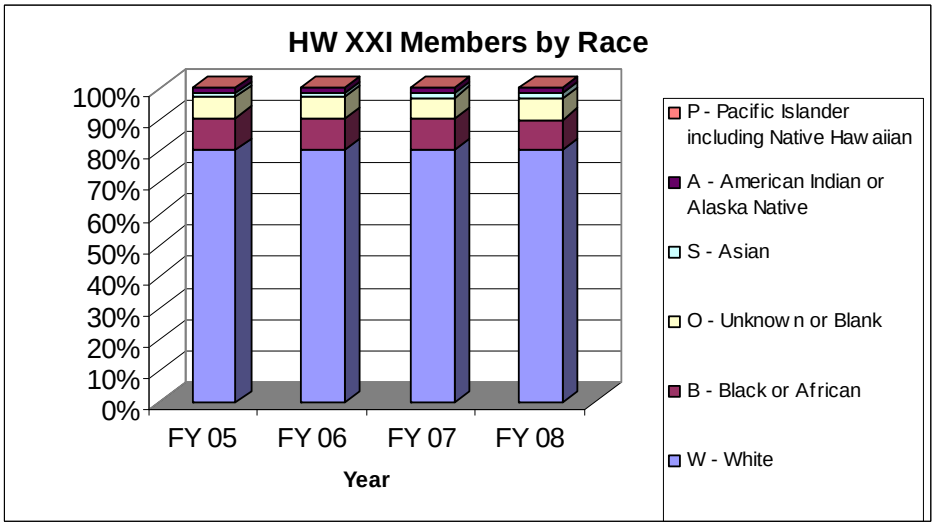


Figure 10

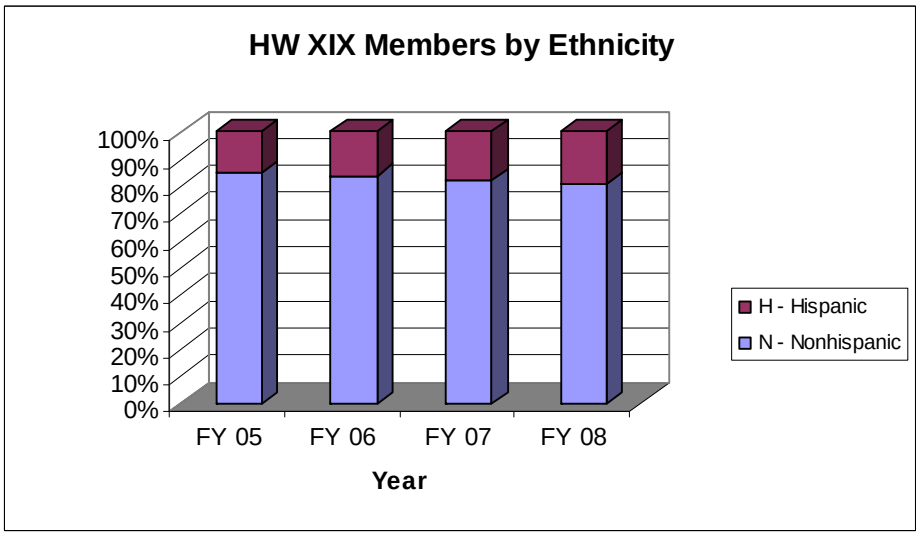
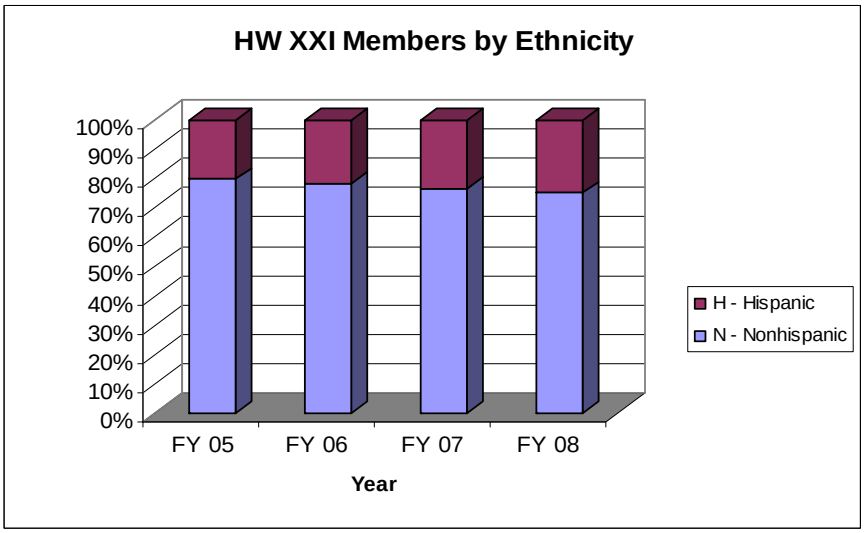
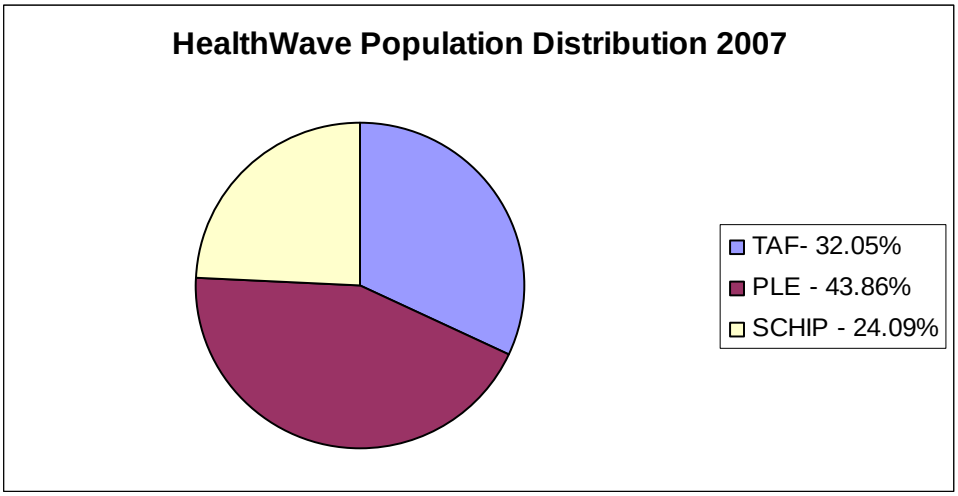


Figure 11



A comparison of the distribution of ethnicity across HealthWave XIX and HealthWave XXI shows a larger percentage of Hispanic members in HealthWave XXI. The data depicts a 5% increase of Hispanics in both programs from 2005 to 2008. In 2006 federal citizenship and identification requirements resulted in a backlog of 20,000 HealthWave applications. Separate analysis of the backlog indicated a disproportionate negative impact on African-Americans, but not on Hispanics.

Figure 12



The HealthWave program consists of those members who are eligible for Medicaid (Title XIX) under the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) programs, or SCHIP (Title XXI). The chart above depicts 75.91% of the HealthWave population as HealthWave XIX members.

Trends in HealthWave FY 2004 – FY 2007

Figure 13

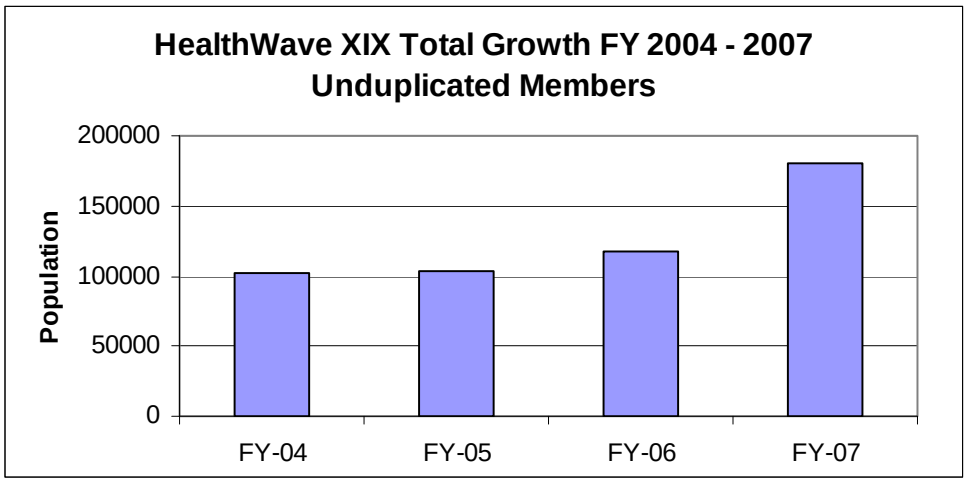
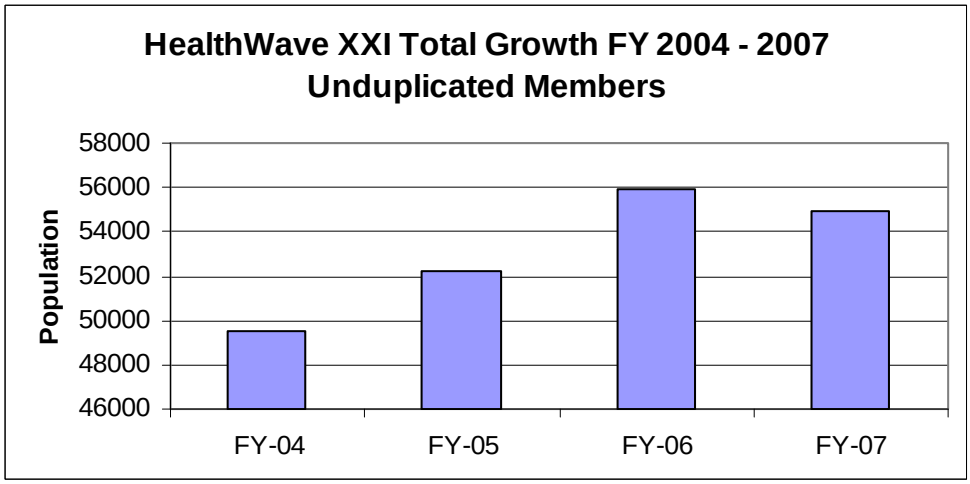


Figure 14



Information in this section represents the growth in unduplicated members from FY 2004 – 2007. Both HealthWave XIX and HealthWave XXI experienced positive growth. However, HealthWave XIX grew significantly faster from FY 2005 – 2006. This increase is attributed to removing the cap on the number of Medicaid beneficiaries that the previous Medicaid managed care organization served. There was also an increase in enrollment in HealthWave XIX from FY 2006 – 2007. This represents program growth due to the transition to multiple MCOs. The decline in membership of HealthWave XXI in FY 2007, (shown in Figure 13) is related to the spillover effects of the backlog created by the federal citizenship documentation requirements. The approximately 20,000 person decline in FY 2007 HealthWave XIX due to citizenship documentation is masked in Figure 12 by the larger increase in enrollment that year following the transition to multiple MCOs.

Analysis of Program Expenditures FY 2004 – FY 2007

Information in this section was obtained from the Management and Administrative Reporting (MAR) system, and reflects HealthWave MCO and carve-out expenditures for FY 2004 – 2007.

Figure 15

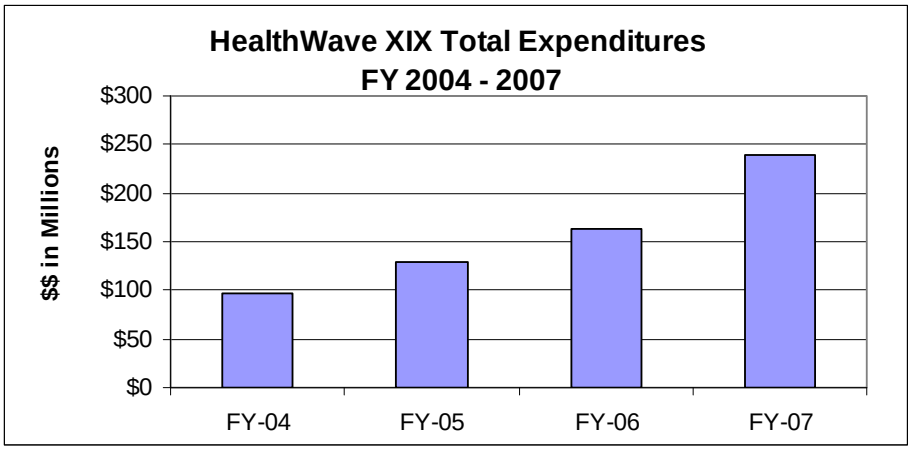
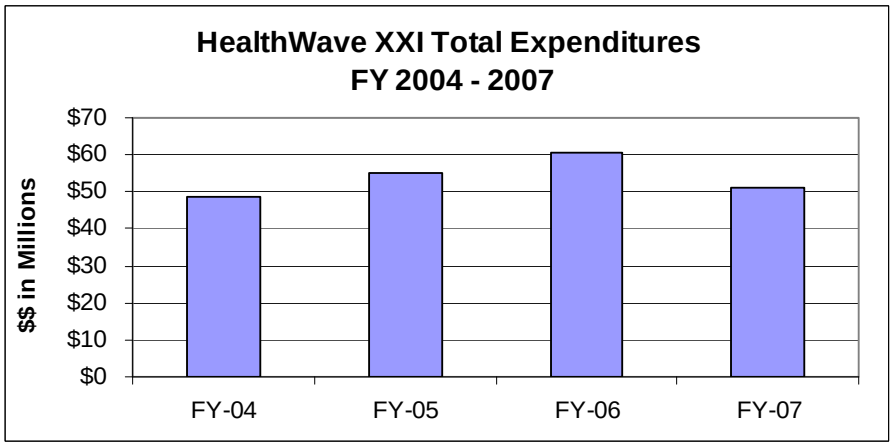


Figure 16



Both HealthWave XIX and HealthWave XXI experienced population changes during FY 2006 – 2007. There is a direct correlation between the growth in membership (as identified in the previous section) and the total expenses for these populations.

Figure 17

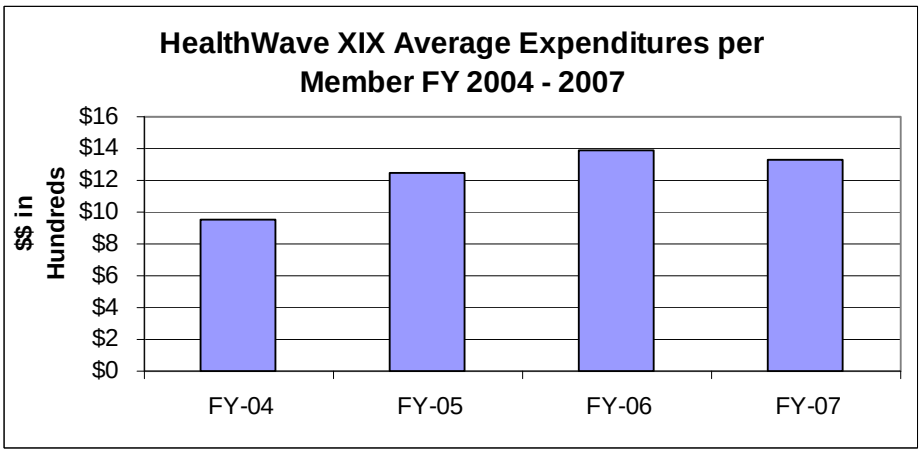
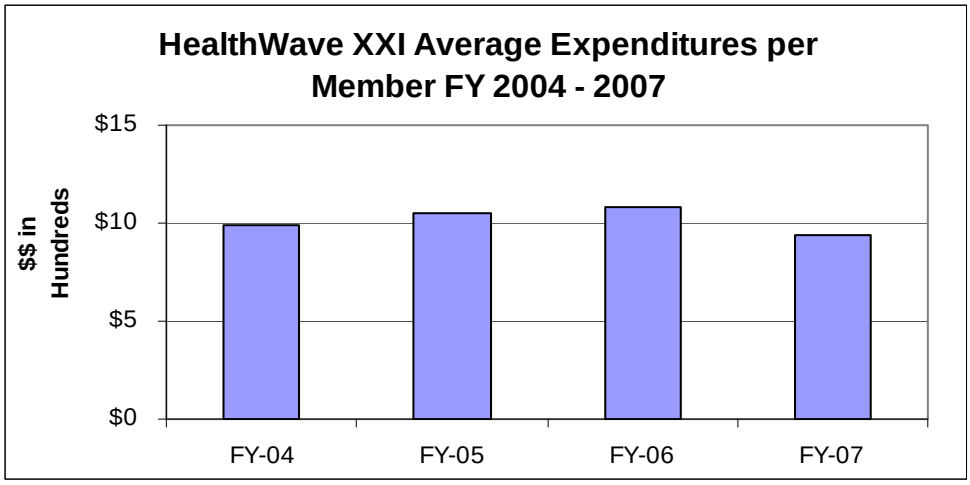


Figure 18



HealthWave XIX and HealthWave XXI both experienced an increase in the average expenditure per member through FY 2006. However, FY 2007 reflects a downward trend. This is directly related to changes in HealthWave XIX and XXI reimbursement rates negotiated with the new managed care organizations (MCOs). It also includes some payment delays to the MCOs associated with the transition.

Quality and Oversight

The Kansas Health Policy Authority, UniCare Health Plan of Kansas and Children's Mercy Family Health Partners are committed to ensuring quality health care for HealthWave beneficiaries. This is accomplished through a number of means, such as: using industry standard reporting tools; various quality of care projects; onsite oversight of MCO activities; and routine reporting. Table 5 contains a short list of some activities used to assess the quality of services and the care provided to membership. Items 1 – 6 are slated to be completed in 2008, while items 7 – 10 are management reports that KHPA routinely receives. Results will be shared periodically throughout the year on the KHPA website, and will be summarized and evaluated in the 2009 annual Medicaid review.

Table 5

	Deliverable	Frequency
1	Consumer Assessment of Health Care Providers and Systems (CAHPS) – Consumer Satisfaction Survey	Annually, Fall
2	Provider Satisfaction Survey	Annually, Fall
3	Two Performance Improvement Projects (PIP) per year (January & July)	Annually, Fall and Spring
4	Select Health Employer Data Information Set (HEDIS) measures	Annually, Summer
5	MCO Contract Compliance Review	Annually, Fall
6	Early Periodic Screening Detection and Treatment (EPSDT) Report	Quarterly
7	Lead Screening Report	Quarterly
8	Grievance and Appeal Logs	Quarterly
9	Pharmacy Ranking Reports	Quarterly
10	Access to Care Report	Quarterly
11	Provider and Member Call Center Statistics	Monthly
12	Provider Network Report	Monthly
13	CMS Managed Care Program Audit	Bi-Annually

During 2007 KHPA fielded a pilot provider satisfaction survey for HealthConnect (the Medicaid primary care case management health care program). KHPA also required the HealthWave MCOs to do the same. In the development of these surveys, there were four questions that were required for comparison across programs. They were:

- In comparison to all of your other patients, (HCK/CMFHP/UniCare) patients are just as educated regarding the use of their medical insurance cards.
- In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the tests and treatments they need.
- In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the prescription drugs they need.
- I am satisfied with being a PCP/PCCM in the (HCK/CMFHP/UniCare) program.

Responses to these questions were predominately positive, and reflect an overall satisfaction in these key areas. The most opportunity for improvement was in member education (results in Figures 18 – 21). In this initial pilot, the provider surveys for UniCare and CMFHP were self administered. Response rates (10.9 - 37.5%) and sample sizes (673 – 1,000) were small. We are unable to report statistically significant differences across plans. Next year's surveys will be administered independently by a third party which will provide more reliable and comparable results.

Figure 19

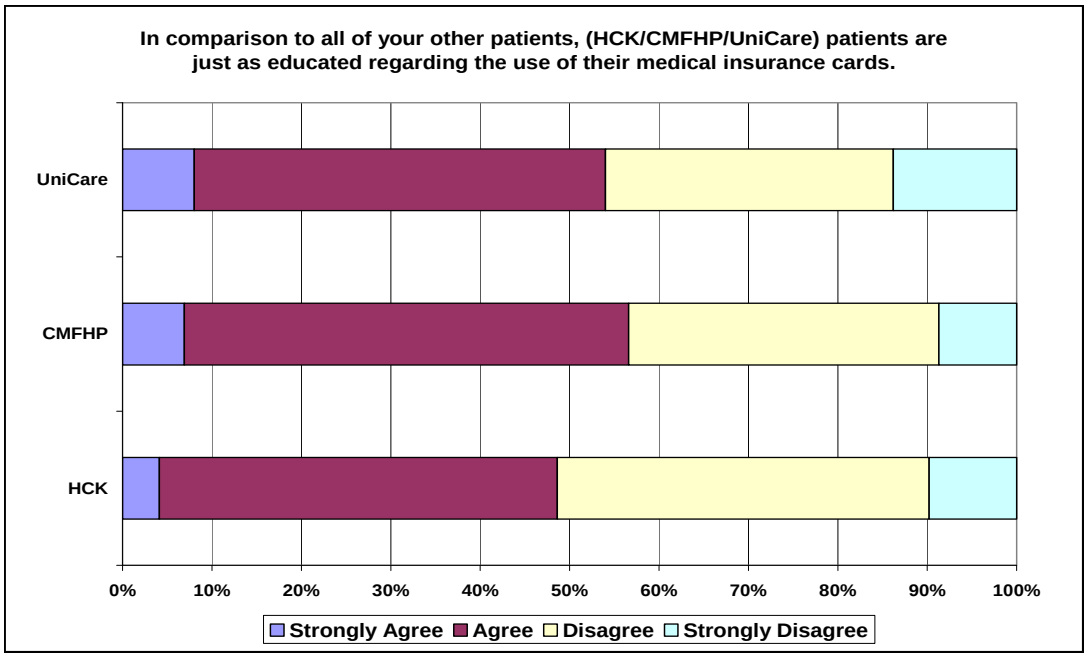


Figure 20

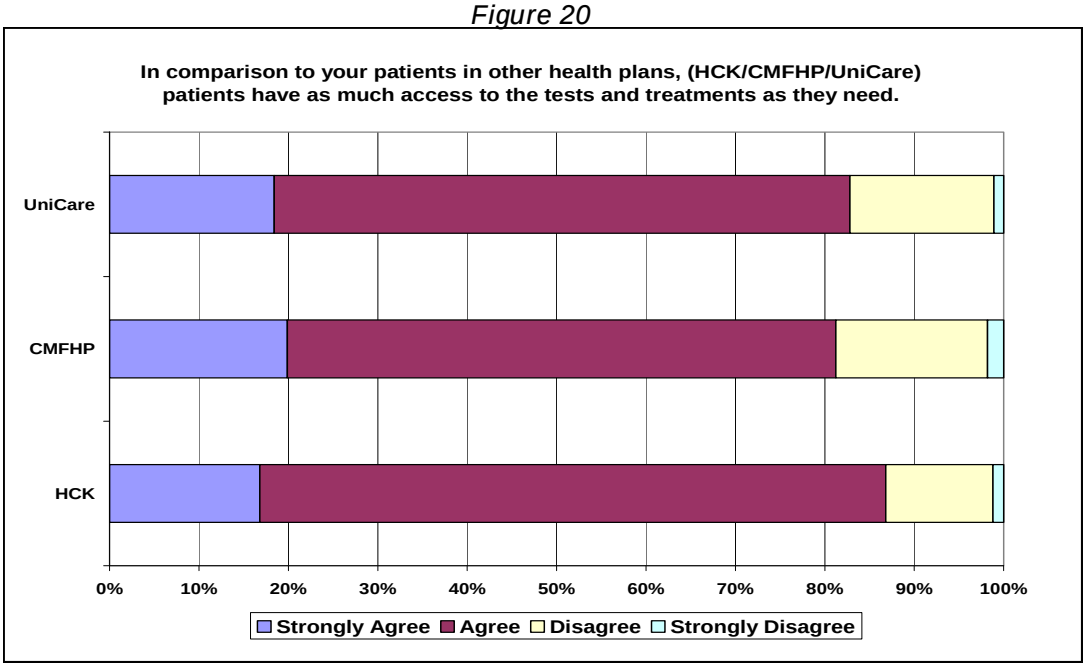


Figure 21

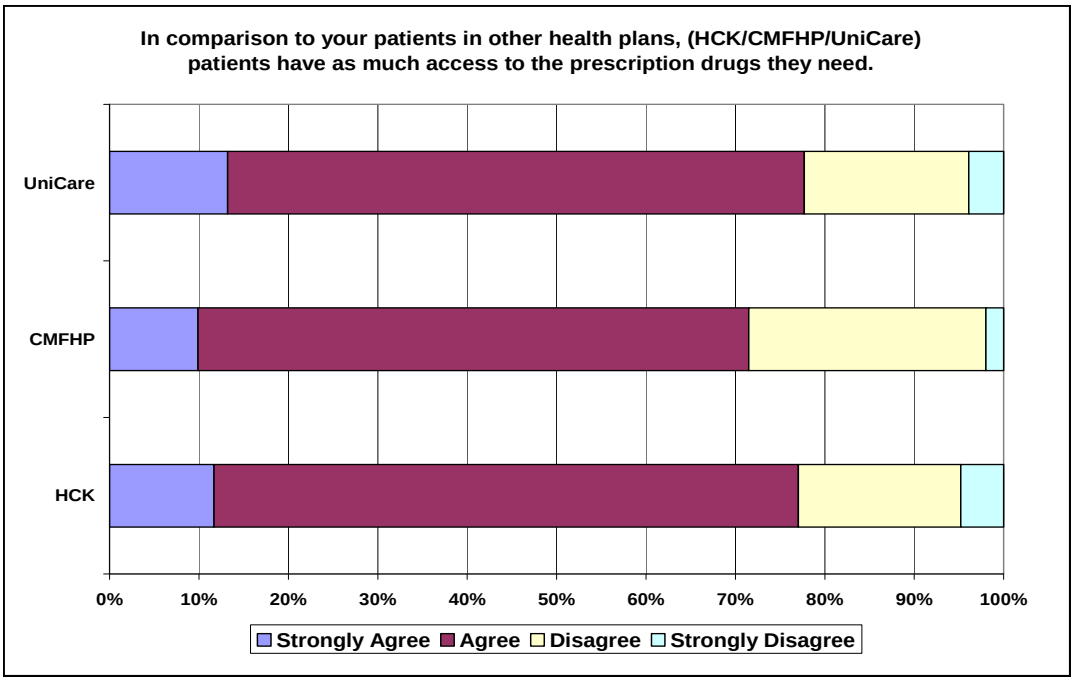
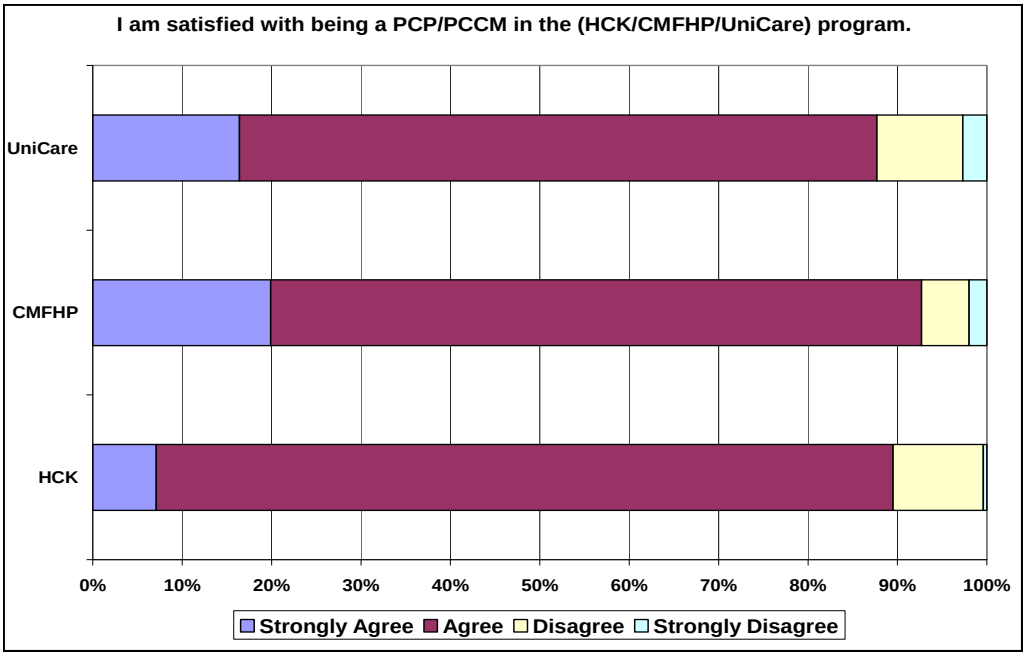


Figure 22



CMS Review

In April 2008, CMS performed an onsite review of Kansas SCHIP and Medicaid Managed Care programs. During this visit CMS reviewed KHPA adherence to several items: federal laws and regulation; SCHIP eligibility determination process; KHPA contract management practices; internal MCO practices; member notifications processes; and KHPA reporting to CMS. Overall, the CMS response was very positive and productive. CMS identified a number of "noteworthy practices," presented "recommendations" for improvements, as well as a few "findings" requiring action.

Conclusions

KHPA has contracted with UniCare Health Plan of Kansas and Children's Mercy Family Health Partners for 18 months. During this time, there have been a number of operational issues which the MCOs responded quickly to correct. This reduced the impact felt by membership and network providers. Now that the MCOs have created stable operational environments, KHPA will shift its focus to assessment of the services being offered. This quality assessment will be accomplished through a number of means, utilizing industry standard tools such as Consumer Assessment of Health Plan Survey (CAHPS), Health Effectiveness Data & Information Set (HEDIS) measures, and Provider Satisfaction Surveys. Onsite audits will be performed to ensure that the MCOs continue to meet their contract requirements. KHPA is currently in the process of validating encounter data (administrative health care records) from the MCOs to ensure accurate reporting, as well as working internally and externally to create better management reports. Results of these assessments will be shared on KHPA's website as it becomes available, and will be evaluated in the 2009 annual Medicaid review.

Milestones during 2007 and 2008 included:

- The transition to two MCOs offering more choice in health care services to approximately 160,000 HealthWave XIX and XXI beneficiaries.
- Process improvements were implemented to ensure better service and responsiveness from both MCOs.
- Care Management Programs rolled out by the MCOs for pregnant mothers, those with chronic disease, and to promote healthy lifestyles.
- Quality Improvement Projects identified, approved and established by MCOs.
- MCO-sponsored educational opportunities for both members and providers.
- MCOs are developing satellite offices in larger communities across Kansas to create access points for beneficiaries and providers.
- MCOs are up-to-date on submission of encounter data and KHPA has begun assessment of this data for validity.
- The creation of a Kansas Member Care Collaboration between the physical health MCOs, CBH, the PIHP and PAHP, to foster collegial relationships between plans and improve treatment plan development across physical and mental health spectrums.

Expected activities for 2009

Rates in FY 2009 and beyond will be set for the two physical health MCOs using an actuarially sound methodology. KHPA has rebased HealthWave XIX capitation payments for FY 2009. While rooted in the MCOs' original competitive bids, which helped determine the winning contractors, this change represents an improved and consistent approach to rate development. HealthWave XIX and XXI actuarial rates were developed by an external organization using a HealthWave XIX membership comparison group and HealthWave XIX and XXI historical encounters. As a result of the change to the reimbursement structure for the physical health MCOs, KHPA expects a slight reduction in FY 09 capitation rates of approximately 1%.

As a component of the legislature's health reform activities in 2008 (SB81), the HealthWave XXI program was authorized to be expanded from an eligibility threshold of 200% of the Federal Poverty Level (FPL) to a threshold of 250% FPL. The expansion is contingent upon the availability of federal matching funds for HealthWave XXI. However, the most notable risk to the HealthWave program has been the inability of Congress to reauthorize SCHIP, the Federal funding source for

HealthWave XXI. Though it was funded through March 2009, neither new funds for increased participation in Kansas' current program, nor funds for expansion to 225% or 250% of poverty were included. The future of SCHIP funding, and the pending expansion of HealthWave XXI in Kansas, will be left to the new president and Congress.

Recommendations

In order to assist in beneficiary plan selection and inform program policy changes, the KHPA will make performance and quality data available for consumers, policymakers and other stakeholders in FY 2009, and will incorporate an evaluation of this performance into the 2009 HealthWave program review.

Definitions

Blended Family—Those families in HealthWave that have members enrolled in both HealthWave XIX and HealthWave XXI.

Category of Service (COS)—Identifier used to report types of service in a consistent manner.

Federal Poverty Level (FPL)—Income level index used to identify eligibility in the HealthWave XIX and HealthWave XXI programs.

Fee-For-Service (FFS)—Coverage methodology in which a provider of service is reimbursed by Kansas directly for services rendered.

HealthWave XIX—The portion of HealthWave comprised of members that receive Medicaid as their source of coverage. These members fall into either the Temporary Assistance to Families (TAF) or Poverty Level Eligible (PLE) aid categories. (See Attachment 1)

HealthWave XXI—The portion of HealthWave comprised of members that receive the State Children's Health Insurance Program (SCHIP) as their source of coverage. This group is made up solely of children 18 years and younger between 101 -200% of the Federal Poverty Level (FPL). (See Attachment 1)

HealthConnect Kansas—The Primary Care Case Management model of managed care in which KHPA contracts directly with primary care providers to act as "gatekeepers" by providing medical homes and referrals to specialty care for certain Medicaid members.

Managed Care Organization—A company through which medical coverage is administered.

PAHP—Prepaid Ambulatory Health Plan offering mental health treatment to Title XIX members. Contract is administered by SRS.

PIHP—Prepaid Inpatient Health Plan offering substance abuse treatment to Title XIX members. Contract is administered by SRS.