

Review of the
Implementation
of the Florida
Kid Care Act

By
Staff of the
House of
Representatives
Health Care
Services Committee



September
1999

Review of the Implementation of the Florida Kidcare Act

Table of Contents

Executive Summary	1
Background	2
Methodology	6
Findings	7
Recommendations	19

EXECUTIVE SUMMARY

The Florida Kidcare program was created by the 1998 Legislature in response to the large number of uninsured children in the state and the enactment of the Child Health Insurance Program under Title XXI. Florida Kidcare offers insurance to uninsured children, depending on their needs and eligibility, through four components: Medicaid, Medikids, Florida Healthy Kids, and the Children's Medical Services (CMS) network which includes a behavioral specialty care network. In response to the Legislature not adopting legislation relating to the Florida Kidcare program during the 1999 session, the Speaker of the House of Representatives assigned an interim project to the House of Representatives Committee on Health Care Services to review the implementation of the Kidcare program and to analyze in more detail the issues that arose during the 1999 session.

In summary, this report makes the following findings: Kidcare is meeting its philosophical goals; customer satisfaction in Kidcare is high; consumers are generally satisfied with the Kidcare benefit package, but are concerned about the limited dental care that the program provides; some of Kidcare's first year enrollment goals have been achieved; slow enrollment may prevent Florida from spending the current Kidcare appropriation; outreach for Kidcare has worked extremely well; Florida's Kidcare Program is complex, which has led to difficulty and confusion for applicants, providers, and professionals; the single-page application form and mail-in submission process have been very well received, but the eligibility/intake processing system has been a problem for applicants and medical providers; the agencies involved with the program have exhibited an unprecedented level of cooperation in implementing the program; while many advocates feel that the Healthy Kids local match requirements should be eliminated, the fact remains that local matching funds allow for more enrollment slots statewide; there are a number of unique issues relating to migrant farm worker and immigrant children that may create difficulties in obtaining Kidcare coverage; and a significant population of Florida's children will lack insurance coverage unless Florida offers state-funded Kidcare coverage for those children who are excluded from federal Title XXI funding.

This report makes twelve recommendations to improve the Kidcare program which deal with the following issues: information from forthcoming evaluation reports; the structures, relationships, and roles of the Kidcare program; statewide implementation, local match, waiting lists, and other Healthy Kids Corporation areas of concern; development of a multi-agency, multi-year budget plan; Kidcare administrative procedures and interaction among the various agencies; budget amendments, as needed, to maximize program enrollment; presumptive eligibility; continuous eligibility; possible medical expense disregards for the CMS network; state-funded coverage for children not eligible for Title XXI funds; and a Healthy Kids dental pilot project.

BACKGROUND

The Purpose and Origin of the Florida Kidcare Program

◆ Title XXI State Children's Health Insurance Program

In response to concerns about the millions of uninsured children in the nation, Congress allotted, through the Balanced Budget Act of 1997 (P.L. 105-33), approximately \$40 billion over 10 years to help states expand health insurance coverage to children, either through Medicaid or other health plans. The act, which created Title XXI of the Social Security Act, initially allocates funds to states based on the number of uninsured children in a state and subsequently on the number of low-income children residing in a state. The law allows the use of funds for "targeted low-income children." States may set income eligibility at up to 200 percent of the federal poverty level, or at 50 percentage points above their existing eligibility level as of June 1, 1997, whichever is higher. The federal law allows states to expand coverage for children by either expanding the existing Medicaid program, or by creating or expanding a separate program specific to the children's initiative, through the use of a federally established "benchmark" coverage plan. States are also permitted to expand coverage through a combination of these two efforts. Children who are eligible for services under Medicaid are specifically prohibited from coverage under the new initiative. Florida was one of three states to have an existing child health insurance program (Florida Healthy Kids Corporation) grandfathered in as part of the federal act.

In order to be eligible to receive federal funds under this initiative, a state was required to submit a State Plan for approval by the federal Department of Health and Human Services (HHS). While the states are given broad authority to design programs to meet a state's specific needs, the plan must detail how the state intends to use the funds. The state plan must describe eligibility standards (income and asset limits, age, geography, residency, duration), benefits (which must meet certain federal thresholds), delivery methods, utilization controls, Medicaid eligibility screening, cost-sharing requirements, maintenance-of-effort, outreach efforts, administrative processes, and coordination with other coverage programs. Once the plan is approved, a state can implement its program and start drawing down federal funds.

The Child Health Insurance Program under Title XXI differs from Medicaid in that it allows an enhanced federal match rate, is a block grant from the federal government, and is not an entitlement program. States may impose limited cost sharing (premiums, deductibles, and co-insurance).

Under the Florida Medicaid Program, the match rate is 56 percent federal and 44 percent state funding. The Title XXI program established an enhanced federal match of 69 percent federal and 31 percent state funding. An annual appropriation of \$270 million in federal funds is available for Florida for the first three years. If the state does not use all of its federal allocation in any year, that money can be "carried forward" for use in the subsequent 2 years. Title XXI requires that 90 percent of funds be expended for health insurance coverage for children. No more than 10

percent of the total amount of federal funding may be expended for outreach, administration, and other costs to administer the program.

◆ **Florida Kidcare Program**

Florida has one of the nation's largest uninsured populations. Nearly 23 percent of those below the age of 65 are uninsured. Despite eligibility expansions in the Medicaid program and an increase in enrollment in the Florida Healthy Kids Corporation, it was estimated in 1998 (based on a 1993 Rand study) that more than 823,000 Florida children were uninsured. Of this number, an estimated 293,885 lived in families that were potentially Medicaid eligible due to family income being below 100 percent of the federal poverty level (FPL); 259,336 lived in families with income between 101 and 200 percent of FPL; and 270,246 lived in families with income in excess of 200 percent of the federal poverty level. (The current federal poverty level for a family of four is \$16,700.)

The Florida Kidcare program was created by the 1998 Legislature in response to the enactment of Title XXI and the large number of uninsured children in the state. The components of Kidcare are as follows. *See Appendix A for a pictorial representation of the components.*

- **Medicaid for Children** -- Medicaid for children includes what was the existing Medicaid program for children with the following eligibility limits: 185% FPL for children 0-1, 133% FPL for children 1-6, and 100% FPL for children 6-15. In addition, the Medicaid portion of Kidcare was expanded to cover children 15-19 between 28% FPL and 100% FPL.
- **Medikids** -- Medikids provides the Medicaid benefit package for children ages 0-5 with family income up to 200% FPL who are not otherwise eligible for Medicaid, using the Medicaid administrative infrastructure, paying Medicaid reimbursement rates, and using Medicaid providers, with one exception. Medicaid enrollees may choose MediPass (a primary care case management program) or a Medicaid HMO in any Florida county. Medikids enrollees, however, may only select a MediPass provider in counties with fewer than two Medicaid-participating HMOs.
- **Florida Healthy Kids** -- Healthy Kids covers ages 5-19 with family income up to 200% FPL and is administered by the non-profit Florida Healthy Kids Corporation (FHKC). FHKC is provided for in s. 624.91, F.S., and has been in existence since 1989.
- **Children's Medical Services (CMS) Network** -- The CMS Network serves the health care needs of children with serious or chronic physical or developmental conditions who require extensive preventive and maintenance care beyond that required by typically healthy children. The CMS Network is a case-managed system of care that links community-based health care with multi-disciplinary, regional, and tertiary pediatric care to provide prevention and early intervention services, primary and specialty care, as well as long term care for medically complex, fragile children. A sub-component of the CMS Network, the

Behavioral Specialty Care Network provides behavioral health care services for children with severe mental health and substance abuse problems.

- **Employer-Sponsored Dependent (ESD) Coverage** -- The employer-sponsored dependent coverage component of Kidcare (when implemented) will allow the state to subsidize purchase of children's coverage through the parents' employer-sponsored group health plans. (The ESD coverage will not take effect until it is approved by HHS.)

With the exception of the Medicaid component, the Florida Kidcare program is not an entitlement. Florida Healthy Kids is the largest non-entitlement component under the Florida Kidcare Act. FHKC is unique from the other components in that it operates with a combination of local, state, and federal dollars, family contributions, and has required counties to contribute funds to support the health insurance subsidy for families since its inception. Currently, counties contribute funds to support the health insurance premiums with a maximum contribution established at 20% in the fourth year of operation. The statute authorizes the Healthy Kids Corporation Board of Directors to establish a base number of enrollment slots in each county that do not require any local match. Currently, each county may enroll 500 children without any local match being required. The statute also authorizes the program to vary local matching requirements and enrollment by county, based on a variety of factors which may influence the county's ability to generate local match.

As of August 31, 1999, FHKC was enrolling children in all but 14 Florida counties. In addition to its Title XXI-subsidized population, Healthy Kids also covers children who do not qualify for Title XXI subsidies. As of July 1, 1999, of the total Healthy Kids caseload of approximately 91,000 children, 609 children are non-qualified aliens, children of state employees, or 19 year olds. Healthy Kids receives no federal Title XXI funding for these children.

◆ **Implementation Process**

The Florida Kidcare program has been implemented in three phases. An initial Child Health Plan (Title XXI) was submitted by the Governor, with approval from the President of the Senate and the Speaker of the House of Representatives, to HHS on December 2, 1997. Phase One of the plan included an expansion of the Florida Healthy Kids Program to additional counties and more children, and extended Medicaid coverage to children ages 15 to 19 with family income between 28% FPL and 100% FPL. Florida's Phase One plan was approved by HHS on March 5, 1998, and became effective April 1, 1998.

During the 1998 session, the Florida Legislature enacted the Florida Kidcare Act, chapter 98-288, Laws of Florida. On July 17, 1998, Florida began efforts to establish Phase Two of the program by submitting a plan amendment to implement several components of the Kidcare program to provide coverage up to 200% FPL for: Medikids, ages 0-5; the Healthy Kids program, ages 5-19; and the CMS network for children who have special physical, developmental, or behavioral health care needs. The Phase Two plan amendment was approved by HHS August 8, 1998, with a retroactive July 1, 1998, effective date.

In December 1998, Florida submitted another plan amendment to implement the Phase Three component of the Kidcare program. The Phase Three plan will implement the employer-sponsored dependant coverage, for ages 0-19. This coverage was originally scheduled to begin January 1, 1999; however, it is still under negotiation with HHS. That negotiation hinges on what is an acceptable level of employer contribution to dependent coverage.

◆ **Review of the 1999 Legislative Actions**

Several different interest groups, including the Legislatively-created Kidcare Coordinating Council in the Department of Health, proposed various Kidcare program revisions during the 1999 session, none of which were adopted. These included revisions relating to: assignment of Medikids enrollees for whom no choice of provider is made at the time of enrollment (mirroring the current process used in Medicaid for MediPass enrollees.); a dental pilot project; children under age 19 being made presumptively eligible for Medicaid, subject to applicable federal regulations; allowing children who are non-qualified aliens or ineligible for federal funding under Medicaid or Title XXI to enroll in the Florida Kidcare program and their coverage to be provided using state-only funds; and authority for the Healthy Kids Corporation to reduce or waive local match requirements, subject to funds being specifically appropriated for this purpose.

The failure of these Kidcare revisions to be adopted during the 1999 session was a great disappointment to many people, and undoubtedly some of these issues will appear again during the 2000 Session. To analyze these issues in more detail, the President of the Senate and the Speaker of the House of Representatives assigned interim projects to the Senate Committee on Health, Aging and Long-term Care and to the House of Representatives Committee on Health Care Services, respectively, to review the implementation of the Kidcare program. The purpose of the project is to determine the major strengths and weaknesses of the Kidcare program and to identify any possible changes in the law or program administration that would improve the program.

METHODOLOGY

Staff met with and had discussions with staff of the Department of Health (DOH), the Agency for Health Care Administration (AHCA), the Department of Children and Family Services (DCF), the Healthy Kids Corporation, the Department of Insurance, and the Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies. In addition, staff conducted two public forums on Kidcare, one targeted at agency and governmental experts, the second targeted at community and constituent experts on the program. Staff reviewed information from the National Academy for State Health Policy regarding other states' CHIP programs, as well as many other publications generated by a variety of interested parties at the national, state, and local levels. Staff reviewed the results of research projects which have studied Kidcare and Title XXI programs in other states, and the results of surveys and focus groups conducted by local Kidcare agencies. Staff attended a Florida Kidcare Coordinating Council meeting in which agency reports were presented and recommendations were developed. Staff also attended regional and Board of Directors' meetings of the Florida Healthy Kids Corporation. Finally, staff solicited input and recommendations from individuals and groups representing people who are enrolled in the Kidcare program or who are providers of services under the Kidcare program

FINDINGS

This interim project is one of several activities designed to review the initial implementation of the Florida Kidcare program. Section 44 of Kidcare's enabling legislation requires AHCA to submit, by January 1 of each year, an evaluation of the Kidcare program to the Governor and the Legislature. As required by law, the agency has contracted with the Institute for Child Health Policy for the required study. Preliminary reports were issued in March and August, 1999. Additionally, FHKC has contracted for ongoing studies of its operations, as have other entities involved with Kidcare.

Likewise, the Kidcare Coordinating Council is in the process of collecting and prioritizing recommendations from its members. Preliminary results from a Kidcare Coordinating Council survey initially distributed at the August 4, 1999, council meeting show that some of the issues members feel should be given high priority include: expanding continuous eligibility to twelve months for all Kidcare components; adopting presumptive eligibility for Medicaid-eligible and Title XXI children; and allowing eligible farm worker children to maintain enrollment in Kidcare as they move to a new harvest area. The survey also indicated council member interest in a variety of other issues, but there was not a consensus as to the priority of these other issues. Final reports and recommendations from these activities will be coming to the Legislature in the months between the release of this report and the beginning of the 2000 Legislative Session.

In addition to studies of the Kidcare program, a comprehensive study of Florida's uninsured is currently being conducted. The Florida Health Insurance Study (FHIS) is a research project designed to provide the most up-to-date and reliable information on health care coverage and access in the State of Florida to public officials, policymakers, and the public. AHCA is conducting this study in conjunction with the University of Florida, to provide current and accurate estimates of the number and percentage of Florida's non-elderly residents who are uninsured. The study will provide information on the rates of uninsurance in Florida's population and the effect of implementation of welfare reform on insurance coverage, medical indigency, and the numbers of former welfare recipients who lose coverage and do not replace it.

Florida created a program which is a combination of Medicaid expansions and public/private partnerships, with a wrap-around system serving children with special health care needs. Florida's Kidcare system is actually four separate programs operated collaboratively: an expanded Healthy Kids Corporation, Medikids, Medicaid for children, and the CMS network. The combined elements form a predominately privatized program administered in a collaborative fashion by multiple state agencies in combination with private business. The design of Kidcare operations and coverages seeks to maximize coverage for eligible children and federal funding participation for Florida, while avoiding the creation of an additional entitlement program.

Kidcare is meeting its philosophical goals.

Kidcare is meeting its goal of making affordable health care coverage available to low and moderate income children in Florida. Further, it is doing so in a manner which treats low and

moderate income Floridians as customers, maximizing participants' sense of personal responsibility and self-worth by allowing them to contribute financially to the health care of their children via premiums and copayments.

Customer satisfaction in Kidcare is high.

The results of surveys and focus groups indicate that the goal of a 90% satisfaction rate among Kidcare participants was achieved. Preliminary findings from the legislatively-mandated evaluation of the program showed that 91% of Medikids and 96% of Healthy Kids parents are “satisfied” to “very satisfied” overall with the program. (These satisfaction rates are the results of an Institute for Child Health Policy survey entitled, “The Kidcare Caregiver Survey,” which was conducted with parents whose children have been enrolled in the Kidcare Program for six months or longer.) Another effect of the program which is present in participant comments is that low-income parents believe that enrollment of their children in health insurance is the right thing to do, and that children without health insurance are treated like second-class citizens. Parents cite cost as the primary barrier to obtaining traditional coverage. The presence of an insurance product which is easy to navigate, affordable, and provides ready access to quality medical care is perceived in a very positive manner, and has given low income parents the ability to do, on their own, what they see as the right thing for their children.

Consumers are generally satisfied with the Kidcare benefit package - with one exception: the lack of dental care coverage.

Consumer focus group results indicated that persons participating in the Kidcare program were generally satisfied with the benefit structure offered by the Kidcare program. A key concern, however, is the limited dental care provided under the Florida Healthy Kids Program. Although the benefit package in the Healthy Kids program is quite good, there is a strong sentiment that more adequate dental coverage should be provided. Dental benefits under the Florida Healthy Kids program are provided as a local option and if included, currently only cover cleaning and x-rays. The Medicaid and Medikids components of Kidcare provide a full complement of children’s dental services.

A number of questions remain to be answered in the Legislature’s decision-making process regarding dental benefits enhancement under the Kidcare Program. Current participation rates of the Medicaid children’s dental program for very low income families are suppressed by what is perceived to be low reimbursement rates for dentists under Medicaid. The impact of enhanced dental services would depend on its attractiveness relative to the existing Medicaid program and whether enhanced services are to be reimbursed at a reimbursement rate that attracts a sufficient number of providers. Enhanced dental benefits could be more attractive than the existing Medicaid children’s dental program which could result in an unintended consequence that participating dentists would discontinue Medicaid participation and thus reduce dental services access for Medicaid-eligible children. A means of addressing this concern would be to “rebase” reimbursement under the Medicaid children’s dental program, combine it with a Kidcare dental program apart from Medicaid, and create a children’s dental program that serves all the Kidcare

components. In doing this, decisions would have to be made as to administration, and federal authorization would have to be sought as to how to administer and pay for such a program.

Additionally, the estimated costs of enhanced Kidcare dental benefits have covered a large range. Actuarial estimates have varied from a low of \$3.78 per member per month (pmpm) to a high of \$11.10 pmpm. The American Academy of Pediatrics in their promotion to include comprehensive dental benefits in a comprehensive health package estimated dental costs at \$21.35 pmpm nationally with a total health cost \$101.47 pmpm. For Florida urban areas, the AAP estimated dental costs at \$26.09 pmpm (total health cost of \$104.01 pmpm) and for rural areas, \$15.98 pmpm (total health cost of \$87.34 pmpm).

The Statewide Dental Coordinating Council has developed a schedule of benefits and a fee schedule to contract with third-party administrators on a prepaid per capita basis or on a prepaid aggregate fixed sum basis. As proposed, a third-party administrator would reimburse providers on a noncapitated basis and would purchase stop-loss insurance to protect against higher than expected utilization rates. Based on the 1997 Medicaid utilization data, the cost of the Statewide Dental Coordinating Council plan is estimated at \$7.74 pmpm. An actuarial estimate for this plan paid for by the Florida Dental Association came to \$4.85 pmpm. Based on the analysis above, it is difficult to see how this rate could support the option of using a non-capitated rate. The association estimates the administrative and stop-loss insurance coverage costs for third-party administrators are at \$2 pmpm.

A work group product jointly developed by the Milbank Memorial Fund and the Reforming States Group has proposed a dental insurance program that would use public funds to achieve enhanced dental access under states' Child Health Insurance Programs. Four levels of care are proposed: diagnosis, prevention, and disease management; basic restorative care; advanced restorative care; and catastrophic care. An actuarial model developed for this proposal estimated that Child Health Insurance Program comprehensive dental benefits costs \$14.50 pmpm, with an additional \$2.50 pmpm administrative cost, based on actual cost experience in Medi-Cal, the state of California's Medicaid program.

After legislation relating to dental coverage for Healthy Kids failed to pass during the 1999 session, a member of the House of Representatives requested that the Healthy Kids Corporation pursue any grant or foundation funding that might be available to fund a dental pilot project. The requirements for this dental pilot project are that the project: be established in not more than two small counties and two large- or mid-size counties over an 18-month to two-year time frame; be designed to assess the dental care needs of Healthy Kids enrollees; consist of a delineated array of services; be delivered by locally-practicing dentists; and provide reimbursement based on the Medicaid fee schedule. The pilot project sites must be willing to meet all applicable quality assurance and access standards, and be willing to comply with established evaluation and outcome criteria. Pilot site selection will be made collaboratively by the Healthy Kids Corporation, the Department of Health, and the Florida Dental Association. As of September 1999, an organizational meeting had been held and several counties have expressed interest in participating in a dental pilot project. In addition, an inquiry was made to HCFA as to whether

dental pilot funds could in some way qualify for any federal Title XXI matching funds, and a positive response to this request has just been received, according to Healthy Kids staff.

Kidcare's first year enrollment goals were ambitious; not all of the goals have been achieved.

Florida set an ambitious goal for the Kidcare program: enrollment of 254,000 children in the first year of operation. As of June 1999, 126,000 children have been enrolled, giving Florida's program the third highest Title XXI enrollment in the nation, behind New York and California. The enrollment goals were not achieved due to a variety of factors including: limited opportunities for open enrollment, difficulty in getting provider networks in place in some counties, the lack of slots in some counties, and negative public perceptions due to early problems in the eligibility/intake system. It should also be noted that Kidcare program funds allocated by the Legislature would not have maximized this enrollment target. (See next subheading for additional, related information.) *See Appendix B for enrollment figures by program component.*

Agency staff underestimated the difficulty of converting Healthy Kids Corporation enrollees who were eligible for either Medicaid or Title XXI funding to those sources, which involved requesting income information from the parents of the nearly 50,000 Healthy Kids program participants who were already enrolled when Kidcare took effect, and screening these individuals for Title XXI or Medicaid eligibility. As of August 1999, of the 50,000 participants who were potential conversions, 8,300 families (13,700 children) had still not responded to multiple requests to provide the required income information. The Healthy Kids Corporation has informed these families that failure to submit the information will result in elimination of the subsidy. With the "last chance" letter the corporation enclosed a coupon, good toward a future month's premium. As of September 8, 1999, of the original 50,000 kids for which conversion was necessary, all have complied with conversion except 4,876, making the conversion project 90% complete.

Enrollment in all the Kidcare components, other than the employer-sponsored component, continues to accelerate. Current projections are for waiting lists to begin to develop by March 2000.

Slow enrollment may prevent Florida from spending the current Kidcare appropriation.

The Florida Kidcare program served 25,291 eligible Title XXI children and spent a total of \$1.7 million (\$0.5 million state and \$1.2 million federal) from April 1, 1998 through June 30, 1998 (Phase One). A total of 126,713 children were enrolled and \$56.4 million (\$16.8 million state and \$39.6 million federal) was spent in FY 1998-99. The FY 1999-00 budget projects to serve an average monthly caseload of 204,459 children at a total cost of \$252.1 million (\$76.8 million state and \$175.3 million federal). While the Governor's Legislative Budget Request sought funding up to the level of 254,000 children, the Legislature funded only up to 204,459.

As a result of the slower than anticipated enrollment, Florida may not spend all of its 1998 federal allotment of \$270.2 million within the allowed three years (10/1/98 - 9/30/00). Any

unspent federal funds may be allocated to other states. Current estimates reflect that \$216.1 million from the first year of federal funding will be spent by June 30, 1999. This leaves a balance of \$54.1 million which must be spent during the first quarter of FY 2000-01. Current spending levels will result in an unexpended balance of approximately \$10.3 million federal funds. The Agency for Health Care Administration estimates that an additional \$126.1 million (\$38.4 million state and \$87.7 million federal) would need to be appropriated in FY 2000-01 to fully fund the unmet need. This will allow the program to serve an estimated additional 81,182 uninsured children under 200 percent of FPL.

Outreach for Kidcare has worked well. Florida's program is held up nationally as a model which has creatively met the needs of a variety of constituencies.

The outreach function in Kidcare is the responsibility of the Department of Health, which has made enrolling children in Kidcare a primary goal for the first year. Focus group responses indicate that Kidcare is gaining a high name recognition, and that outreach workers providing personalized assistance for people enrolling have significantly improved the program's user-friendly reputation.

Seventeen regional outreach projects were funded beginning October 1, 1998. The projects inform policy makers and providers, implement strategies to reach hard-to-reach populations, provide local information and assistance to families, identify barriers to application and enrollment, and enlist the assistance of other health and social service providers in outreach. Projects are uniquely situated to be able to identify pockets of the under-served and target activities to special groups. Perhaps most valuable has been the ability of the projects to locally enhance the public relations campaign for Kidcare.

The outreach component of the program has made applications available at over 5,500 sites throughout Florida. These include schools, county health departments, physician offices, and public assistance offices. Information about the program has been provided to over 25,000 community providers and organizations, and training has been provided to staff in over 2,500 sites to assist families with the application. Over 1,000,000 flyers, brochures, posters, and promotional items have been distributed. An extensive public awareness campaign has helped inform the public about Kidcare. Media campaign components included 2,800 television and 3,400 radio advertisements, 250 outdoor boards, 1,150 bus placards, a website with a downloadable application, and a marketing resource guide.

Recently the Department of Health assumed responsibility for the toll free outreach telephone line to alleviate some of the high demand on the Healthy Kids Corporation hotline. This outreach hotline will provide live operator assistance for people with enrollment questions and application requests during the 1999 Fall enrollment campaigns.

In just its first year, Florida's outreach has been recognized as implementing exemplary strategies and national "best practices" by both HCFA and the National Association of HealthCare Marketing.

During the second year of Kidcare outreach activities, the department plans to do targeted marketing research to identify the barriers families face in enrolling their children in child health insurance and to identify the message that a marketing campaign should use to overcome those barriers.

Florida's Kidcare Program is complex, which has lead to difficulty and confusion for applicants, providers, and professionals.

Title XXI offers states significant flexibility in program design and management. States choosing to participate in Title XXI could either expand Medicaid eligibility, create a unique state-designed program, or develop a combination of these two approaches. Across the nation, 22 states, as well the District of Columbia, have developed their Title XXI programs as Medicaid expansions, that is, Medicaid eligibility was expanded to cover additional children who would otherwise not be eligible, using the Medicaid benefit structure, payment rates, and provider system. Sixteen states created a stand-alone, state-designed program. Twelve states designed programs which are a combination of both options.

The financial eligibility requirements which differentiate whether an applicant ends up in Healthy Kids, Medikids, or Medicaid vary depending on age. If the applicant is a child with special health care needs, he or she will enter an entirely different service delivery system through the CMS network. The intake system for each of the components has different administrative requirements, and the program components have differing levels of enrollment availability. To further complicate matters, in some components, availability and accessibility varies by county, depending on availability of slots, whether the county of residence has been willing or able to raise the required local match, and whether a provider network is present. If a component is not currently holding open enrollment, the application may not be acted on until enrollment re-opens. In addition, since components have different service delivery models, a participant may be mandated to join an HMO, or may be allowed to choose between an HMO or a fee-for-service delivery system. Depending on which component an individual is enrolled in, the family may be charged a premium, and may pay some deductibles.

The existing different financial eligibility criteria, provider networks, and payment rates in the various components create the potential that as a child's eligibility factors change over time (age, income, or physical status), the child may have to move between components of Kidcare, with a resultant change in provider or benefits. The differences in the components mean that in some cases children in families may be assigned to different programs, with different providers. Approximately 5,000 families in Kidcare have children enrolled in two components of Kidcare; 47 families have children in three components. There is no documentation to date that this situation results in a decrease in family satisfaction or causes these families difficulty in accessing medical care for their children. The Institute for Child Health policy has designed a specialized customer survey to assess the effect of enrollment split. The survey will be conducted over a four week period, and it is hoped that survey results will be obtained from over 1,000 families. Results of this survey should be available in November.

The single-page application form and mail-in submission process have been very well received, but the eligibility/intake processing system has been a problem for applicants and medical providers.

Prior to 1998, the process for determining Medicaid eligibility for children included two personal visits to the local DCF office, a requirement to produce documentation, and a face-to-face interview lasting on average 90 minutes, during which all members of a family were reviewed for eligibility for all public assistance programs whether or not the family wanted to participate.

As part of Kidcare implementation, the state agencies administering the Kidcare program developed a simplified application form which can be mailed in and quickly processed. Parents generally see the new application form as straightforward and easy to complete - a major improvement over other public programs. A major plus in the program is that parents can apply by mail without having to go for a lengthy DCF financial interview.

In its first nine months (October 1998 - June 1999), the Kidcare program received and processed 185,000 applications. Though the application form was simple, the process it went through once received by Kidcare was complex. This complexity led to widespread delays and frustration on the part of applicants. In part, this difficulty is due to Florida's program not taking advantage of flexibility under federal law to use a shortcut presumptive eligibility system to get children into the system quickly. Under federal requirements, states have the option to provide presumptive Medicaid eligibility to children and to pregnant women. Under a presumptive eligibility system, an immediate eligibility determination is made by designated entities based on the statements on the application; reported income is verified after the fact. If, on verification, it is discovered that an individual has income over the limits for program eligibility, the applicant is taken off the program. Under federal rules for Title XXI, the state is not required to pay back federal funds spent on behalf of an applicant during the verification period. Presumptive eligibility offers the advantage of providing additional "entry points" into the health care system because health care providers and others can grant temporary coverage on the spot when children go to receive health care services. Under the federal law, the entities that may establish presumptive eligibility for children include: Medicaid providers, entities that determine eligibility for Head Start, WIC, and child care subsidies under the Child Care and Development Block Grant, and "other entities designated by the state."

Florida's choice to not exercise the presumptive eligibility option created a situation in which success was highly dependent on DCF staff being able to process a large volume of applications in a timely fashion. Since the federal law requires Medicaid eligible individuals who were receiving coverage through Healthy Kids to be converted to Medicaid, all applicants for that portion of the program were screened for Medicaid eligibility by DCF. During the Fall of 1998, the combination of open enrollment and increasing outreach and publicity produced a large volume of applications for which DCF was unprepared. By November 1998, a backlog of over 20,000 applications developed. The situation was complicated by the lack of an easy way to determine the status of any given application; the DCF non-automated, paper-based systems developed to provide this information became essentially useless as the volume of backlogged applications grew.

Although the mail-in application system was easier for a citizen to access, it did not provide feedback to the person submitting an application that the application had been received, was being processed, or a way a person could inquire about the status of his or her application. Since the program required the applicant to submit a check as advance payment of the first month's premium, applicants became increasingly concerned about their status. The situation began to produce a huge volume of calls from concerned applicants, providers, and others inquiring about the status of applications. Since there was no number to call at DCF, almost all of these calls made their way to the Healthy Kids Corporation member services lines, which had no way of answering questions other than a laborious manual search process involving wading through the paper DCF logs. The Healthy Kids Corporation's 72 incoming telephone lines were constantly jammed with very long wait and hold times, resulting in a high degree of frustration on the part of everyone involved in the process.

In December 1998, the Healthy Kids Corporation made a unilateral decision to begin sending backlogged applications to its third party administrator for enrollment in the Medikids program, without the required Medicaid eligibility screening. At the same time, DCF began sending backlogged applications out to district offices statewide (rather than only to the four Kidcare processing centers). The backlog immediately began to drop.

Although the backlog has for the most part been eliminated, the intake and eligibility process, along with the lack of information on the status of an application, have had a negative effect on satisfaction with the program. Despite the fact that the agencies involved have made major improvements in the process, the program's public perception still suffers from the earlier problems.

The Healthy Kids Corporation is opening enrollment to coincide with the start of the 1999-2000 school year. Enrollment will be staggered throughout the Fall by county in order to avoid an overwhelming onslaught of applications that must be processed at the same time. Staff will closely monitor application processing in fear of a repeat of last year's problems relating to application backlogs. As of September 1, 1999, the number of backlogged applications over 45 days old is down significantly to 371. In addition, the application and enrollment process system has had several revisions which should expedite the eligibility and enrollment process.

Twelve-month continuous eligibility for all components is another option Florida's program chose not to exercise, and like presumptive eligibility, continuous eligibility may also have prevented some of the administrative difficulties that occurred. Federal law allows states to grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. In addition, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because recertification requirements impose barriers to continued participation.

The five agencies involved with the program have exhibited an unprecedented level of cooperation in implementing the program.

Clearly, Florida's design for Kidcare was one of the most complex in the nation. The design did not designate one agency to be "in charge" of the program with the power or ability to control the activities of the other participant agencies. Kidcare's implementing legislation did however, create the Kidcare Coordinating Council, an interagency body which includes providers, insurers, families using the program, and a variety of program stakeholders, charged with making recommendations concerning implementation and operation of the program. Day-to-day operational decisions and policy changes are made collaboratively by representatives of the Department of Health, the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Insurance, and the Florida Healthy Kids Corporation.

The success of the program has been the direct result of the involved parties' willingness to understand the situation of the other parties, and to cooperate, compromise, and work together to solve programmatic problems as they emerge. In large part the credit for Florida's accomplishments to date should go to the individuals in the leadership positions in each of the agencies, who were able to find solutions to problems, commit their agencies to their part of the solution, and ensure their agencies' follow-through in making the necessary changes.

While many advocates feel that the Healthy Kids local match requirement should be eliminated, the fact remains that local matching funds allow for more enrollment slots statewide.

A local match requirement has been a part of Healthy Kids participation since the inception of the program. Local match provides additional enrollment for counties that desire to increase the total number of children covered in the county. Currently, each county receives 500 "free" slots in the Healthy Kids component, as established by the Healthy Kids Board of Directors. After the free slots are used, the county is required to generate up to 20% local match for additional enrollees. The statute authorizes the program to vary local matching requirements and enrollment by county, based on a variety of factors that may influence the county's ability to generate local match. This authorization has been utilized for the allocation of the "free" slots across all counties.

In some counties, raising local match has proven to be difficult, resulting in waiting lists. According to advocates who believe local match requirements should be replaced, the issue of raising local funds is problematic to many communities, especially small rural counties that have a limited tax base and small business employers. Recently larger counties have also had difficulties, or shown reluctance to, raising local match dollars.

Without the more than \$10 million raised through local matching funds, Healthy Kids would be forced to drastically reduce its enrollment goals for 1999-2000 should these local revenues not be "bought out" by state funds. Local matching funds generate a 69% match by the federal government and allow Florida to insure an additional 40,000 children. Proponents of local match requirements argue that Healthy Kids actually has more enrollment slots available statewide

because of local matching funds. In addition, local match proponents believe that requiring counties to raise local match dollars assures community commitment to child health issues.

The concept of local funding requirements is not unique to Florida's Kidcare program. There are several other examples of local funding requirements for health and social services programs in Florida. Part I of ch. 154, F.S., requires county contributions for county health department funding in partnership with the state. Part IV of ch. 154, F.S., "The Health Care Responsibility Act," requires counties to pay certain amounts for in-county and out-of-county hospital costs for the counties' indigent residents. Section 394.76(9)(a), F.S., specifies that local governments "be required to participate in the funding of alcohol and mental health services," with certain exceptions. Section 409.915, F.S., requires county contributions for a portion of the state's Medicaid funding for certain hospital and nursing home services rendered to a county's residents. These examples clearly indicate that it is not unprecedented that a local match requirement be imposed for state programs.

There are a number of unique issues relating to migrant farm worker and immigrant children that may create difficulties in obtaining Kidcare coverage.

Federal policies relating to immigrants are often complicated and can easily cause confusion when coupled with the seemingly complex policies and requirements of a program like Kidcare. In addition, migrant farm worker and immigrant families may have other concerns or misconceptions that prevent them from applying for coverage, even if their children are eligible.

Language and cultural differences, as well as the lack of knowledge about Kidcare eligibility, can often determine whether immigrants apply for coverage for their children. In addition, recent federal welfare reforms which significantly cut benefits to legal immigrants and refugees and excluded certain groups of children who legally came into the country after August 1996 from participation in Title XXI for five years have led to confusion. Many families fear their child's participation in the Kidcare program may prevent them from becoming a citizen. This fear stems from the concept of "public charge" which has been part of U.S. immigration law for more than 100 years as a ground of inadmissibility and deportation. An alien who is likely to become a public charge is inadmissible and ineligible to become a legal permanent resident of the United States. The concern of being classified as a public charge has prompted non-citizens to deny themselves public benefits for which they are eligible, thus frustrating the government's goal to increase access to health insurance and health care and to help individuals to become self-sufficient through the aid of temporary public support. In May 1999, new federal policy directives were published that clarify the circumstances under which non-citizens can receive public benefits without becoming a "public charge." The new policy clearly states Medicaid and Children's Health Insurance Program benefits are not subject to public charge consideration and such benefits may be received by a non-citizen without concern for negative immigration consequences.

Difficulties may also occur for this population even after coverage is obtained. Because the work of migrants is seasonal, families move from harvest to harvest and their incomes vary during the year. Families may face difficulty in maintaining coverage as they move throughout the year and

access to care may be hindered by lack of knowledge about local providers in the new harvest area.

A significant population of Florida's children will lack insurance coverage unless Florida offers state-only Kidcare coverage.

Federal law identifies children who are not eligible for participation in the Title XXI program. Specifically excluded are children who: were eligible for the Medicaid program under the current categorical eligibility criteria; are dependents of a public agency employee who is eligible for coverage under a state health benefit plan; have other health insurance coverage; do not meet the definition of a qualified alien; or are inmates of public institutions or institutions for mental diseases.

Many families in these populations simply do not have the financial means to obtain health insurance. The fact that parents are state employees who are eligible for coverage under a state health benefit plan does not necessarily mean that their incomes are substantial enough to make it possible for them to afford the coverage offered them. Many state employees earning minimal wages meet the financial eligibility requirements for Kidcare coverage, but are excluded based only on the nature of their employment. In addition, children whose immigration status makes them ineligible under federal law are particularly vulnerable and often have no insurance coverage options. Without coverage, these children are unable to access primary preventive care and are at an increased risk of developing debilitating conditions. In addition, when emergency conditions do arise with these children, health care providers are put in the position of providing costly services without reimbursement. Ultimately, the health care providers, their patients, and the government share the burden of paying for this costly way of providing necessary care that might have been avoided if the child had health insurance and adequate preventive care was available.

Other Issues:

A variety of additional concerns were raised by the Kidcare Coordinating Council, providers, advocates, agency staff, and consumers during focus groups and the meetings staff had with people knowledgeable about Kidcare operations:

- Although the program was designed to provide coverage under a single new program name (Kidcare), the program is not seamless to families and providers. The various categorical demarcations in the program structure are seen as confusing and lead to fragmented coverage for families.
- Simplifying the complicated administrative application processing system is seen as very important. The development and refinement of the single-page application was a major accomplishment. A variety of suggestions have been made, including developing a separate, independent system to process applications and determine eligibility.

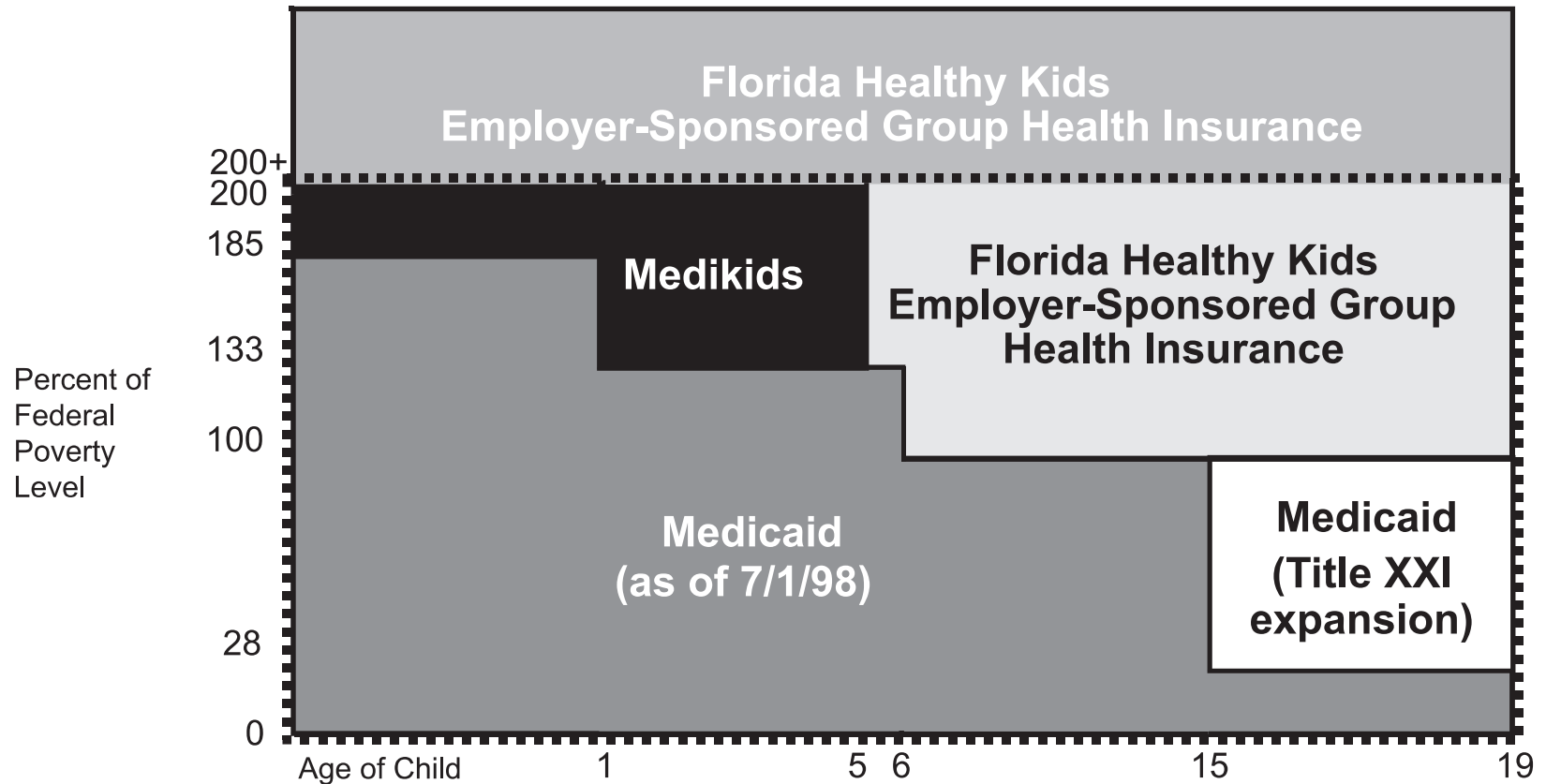
- The 200% FPL limit for any subsidy and the full-pay premium requirements are a burden to families with children with special health care needs. Many interested people recommend that premiums be waived for these children. In addition, recommendations were made that the state institute a medical expense disregard for families with children having special health care needs so that these families could deduct out-of-pocket medical costs from reported income for eligibility determination purposes, thus allowing these families be allowed to “spend down” in order to qualify for the CMS network.
- Mandatory enrollment in HMOs in the Medikids program prevents families from making their own choice of medical providers and has required children to switch away from current providers.
- The waiting period for reinstatement is seen as unnecessarily punitive. In the current program, being late with a premium payment results in a 60 day suspension from the program. Many individuals point out that in the commercial insurance market, payment of premiums results in immediate reinstatement of coverage.

RECOMMENDATIONS

1. Information from preliminary evaluation reports is included in this review. The Legislature should consider the findings and recommendations from the evaluation being conducted by the Institute for Child Health Policy and other studies currently being conducted before finalizing legislation for the 2000 session. If warranted, target enrollment figures should be adjusted based on the findings of the Florida Health Insurance Study.
2. The structures, relationships, and roles of the Kidcare program are continuing to evolve and the entities administering the program are committed to solving identified problems as the program matures. Major structural changes could slow down enrollment of eligible children and should not be made at this time. The agencies involved in implementation are urged to continue to improve administrative areas of the program that may be causing children to remain uninsured and focus on meeting enrollment goals.
3. The FHKC Board of Directors should continue to develop alternatives and solutions for areas of concern, including statewide implementation, local match and waiting list issues in some counties, the difficulty in shifting FHKC enrollees to Medikids and Medicaid in some areas, and the barriers that are unique to migrant farm worker and immigrant families.
4. The agencies involved in Kidcare implementation should develop a multi-agency, multi-year budget plan which projects enrollment, case load, and expenditures for each agency and each Kidcare program component. This plan should include an explanation of the use of federal funding, as well as any additional information that could help the Executive Office of the Governor and the Legislature determine whether benefits could be expanded (e.g., dental benefits), at what levels to fund crucial outreach activities, and how to respond to proposals in Congress to reallocate Title XXI resources.
5. Efforts should be made to identify how Kidcare administrative procedures and interaction among the various agencies can be enhanced. The agencies should work together to find ways to shorten the intake/eligibility time frame and should establish through a formalized inter-agency agreement certain processing time lines that each agency is required to follow. In addition, the agencies should consider administrative changes that might be necessary for Kidcare in the future, such as establishing a central outreach function for the entire program, restructuring the in-take/eligibility process, and eliminating open enrollment periods. Finally, the agencies should work collaboratively on the preparation of a formal monthly report to be provided to the Governor, Speaker of the House of Representatives, President of the Senate, program stakeholders, and the public.
6. To the extent that enrollment ceilings are reached during the 1999-2000 fiscal year, agencies involved in Kidcare administration and the Executive Office of the Governor should prepare and submit necessary budget amendments to maximize program enrollment, and the Legislature should act favorably on these budget amendments.

7. Presumptive eligibility should be adopted for the Medicaid, Medikids, CMS, and Behavioral Health Specialty Care components. Presumptive eligibility may solve problems caused by the current intake/eligibility process, and would provide children with earlier access to primary and preventive care and ensure access to urgent care and care for significant medical problems during the eligibility determination process. The Legislature would need to be specific as to which entities have the authority to determine presumptive eligibility. Under federal law, states may choose the entities they wish to determine eligibility.
8. To the extent that presumptive eligibility does not address newborn enrollment concerns, consideration should be given to moving children age 0-1 between 185% to 200% of the federal poverty level from Medikids coverage to Medicaid. In addition, providing Medicaid coverage for pregnant mothers between 185% and 200% of the federal poverty level should be studied, and agencies should be asked to provide any data indicating health problems of infants who fall into this gap that could have been prevented through access to proper prenatal care.
9. Continuous eligibility should be expanded to twelve months for all Kidcare components to eliminate the problem of children losing their health care coverage due to minor fluctuations in family income, which is common in many low-income families, and to ensure that children will have a guaranteed period of coverage in order to ensure continuity of care. In addition, passive redetermination of eligibility for Medicaid should be implemented, and it should be determined what, if any, statutory change is needed for implementation of this policy revision.
10. Consideration should be given to implementing a medical expense disregard for the CMS network to allow families over 200 percent federal poverty level to deduct the cost of medical care from their incomes for Kidcare eligibility determination purposes.
11. Consideration should be given to the possibility of authorizing state-funded coverage of children of state employees and immigrants. The Healthy Kids component now covers some children from these groups. Possible options, such as creating subsidies for state employees falling under the poverty level or a "buy-in" for family coverage under state employee benefits with a state subsidy, should be analyzed. In addition, consideration should be given to urging Congress to revisit the issue of excluding these groups from coverage under Title XIX.
12. The Healthy Kids Corporation should be encouraged in its efforts to establish the dental pilot project that it agreed to implement in June 1999. Until more definitive service need and cost information is available, the Legislature should be cautious in extending full dental benefits as part of the Healthy Kids benefit package.

Kidcare Structure



- Medicaid Title XIX Funded (Medicaid benefits)
- Medicaid Title XXI Funded (Medicaid benefits)
- MediKids Title XXI Funded (Medicaid benefits)
- Non Medicaid Title XXI Funded (Healthy Kids benefits)
- Privately Funded (Healthy Kids benefits)
- CMS Network coverage for children with special health care needs

Kidcare Enrollment

Kidcare Component	FY 1998-99 Goal	FY 1998-99 Actual	As of Sept. 1999
Children enrolled in the Medicaid program under new eligibility groups (Medicaid for teens)	29,5000	25,499	24,005
New children, previously Medicaid eligible but not enrolled, enrolled due to Title XXI outreach	80,000	Data unavailable*	Data unavailable*
Uninsured children enrolled in Title XXI Medikids	17,000	8,056	10,536
Uninsured children added to Healthy Kids Corporation under Title XXI	70,000	91,011	96,558
Uninsured enrolled in employer-sponsored Title XXI coverage	48,000	0**	0**
Uninsured children in CMS under Title XXI	9,500	2,147	2,770
Total number of previously uninsured children expected to obtain coverage	254,000	126,713	133,869

*No data but new application will track how an applicant learned about the program.

**HCFA has not yet approved this coverage.