Florida KidCare Coordinating Council

2007 Annual Report and Recommendations

Florida KidCare
Coordinating Council

January 22, 2007

Dear Fellow Floridians:

On behalf of the Florida KidCare Coordinating Council, I am pleased to provide you with a copy of the council's 2007 Annual Report and Recommendations. Florida KidCare is our State Children's Health Insurance Program for uninsured children under age 19 who meet income and eligibility requirements. The program, which includes Medicaid for children, Florida Healthy Kids, MediKids, and the Children's Medical Services Network, provides comprehensive health care coverage to 1.4 million Florida children.

The Florida KidCare Coordinating Council represents a diverse group of child advocates, health care providers, local government representatives, health insurers, state universities and state agencies. It was established by the Legislature in 1998 to deliberate and make recommendations to the Governor and Legislature about ways to improve the Florida KidCare Program. The council's 2007 recommendations focus on strategies to accomplish the following objectives:

(1) Reduce child uninsurance in Florida by increasing enrollment and retention;

(2) Simplify the program's administration;

(3) Remove barriers and promote seamlessness when children move between Florida KidCare program components;

(4) Increase statewide awareness about the Florida KidCare program; and

(5) Ensure that sufficient state and federal funding is allocated to support coverage for more uninsured children.

This year, the federal State Children's Health Insurance Program (SCHIP) is up for reauthorization. Currently, the federal government contributes 71 cents for every 29 cents Florida invests in children's health insurance.

Ensuring Florida's children receive their fair share of federal funds for health care is essential, because child uninsurance is on the rise again. The council's federal recommendations identify key issues for Florida's children that require federal congressional action. SCHIP federal reauthorization and increased federal funding for Florida are critical. Other federal recommendations address opportunities for more uninsured children to participate in subsidized coverage.

Working with Florida's leaders, we have accomplished much for Florida's children, but there are more opportunities to further improve this important program. The council remains committed to working with you to ensure Florida's children have access to and retain high-quality, affordable health care.

Sincerely,

Joseph J. Chiaro, M.D., FAAP
Council Vice Chair

Attachment

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(*as of December 2006*)

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The KidCare Coordinating Council gratefully acknowledges the assistance and cooperation of the Florida KidCare partner agencies in providing information needed for the preparation of its annual report:

- Agency for Health Care Administration
- Department of Children and Families
- Department of Health
- Florida Healthy Kids Corporation

Any errors contained in this report are the responsibility of the council's staff, and not the individuals or organizations that provided the original information.

Statutory Authority and Council Composition

The Florida KidCare Coordinating Council, created in Section 409.818(2)(b), F.S., is responsible for making recommendations to the Governor and the Legislature concerning the implementation and operation of the Florida KidCare state children's health insurance program.

Chaired by the Secretary of the Department of Health, the council represents a diverse group of child advocates, health care providers, local government representatives, health insurers, state universities and state agencies.

The full council met throughout Fiscal Year 2006-07 to discuss Florida KidCare issues, learn about the agencies' implementation of new policies and processes, identify additional strategies for improving the program, and develop its recommendations for 2007.

Creation of the Florida KidCare Coordinating Council

409.818 Administration. – In order to implement ss. 409.810-409.820, the following agencies shall have the following duties:

(2) The Department of Health shall:

(b) Chair a state-level coordinating council to review and make recommendations concerning the implementation and operation of the program. The coordinating council shall include representatives from the department, the Department of Children and Family Services, the agency, the Florida Healthy Kids Corporation, the Office of Insurance Regulation of the Financial Services Commission, local government, health insurers, health maintenance organizations, health care providers, families participating in the program, and organizations representing low-income families.

The council's recommendations to the Governor, the Florida Legislature and Florida's Congressional Delegation reflect an understanding of the complexity of the program, issues related to implementation, and the diversity of the population served. The recommendations contained in this report reflect the interests of the council as a whole. Individual members or the agencies or organizations they represent, however, may not support some of the recommendations. The council welcomes input on ideas to reduce the number of uninsured children in our state.

Council Accomplishments

Over time, the council's recommendations, many of which have been adopted, have covered a wide range of legislative, budgetary and complex administrative issues. In FY 2006-07, program changes included:

- MediKids full-pay option for children ages 1 to 5 with family incomes above 200% of the federal poverty level. (The council's recommendation would have included infants under age 1 in the full pay option.)
- Funding the Florida KidCare program to serve children currently enrolled and to allow for growth as projected by the Social Services Estimating Conference.
- $1 million of state funds were allocated for Florida KidCare marketing and outreach grants.
- The Florida Healthy Kids Corporation launched an online application for Florida KidCare, which was a previous council recommendation.

Previous years' recommendations that have been adopted over time include:

- Reinstating year-round open enrollment for the Florida KidCare program controlled by the budget.
- Adopting 12 months of continuous eligibility.
- Allocating state funds to print and distribute "Back to School" post cards for the 2005-06 school year.
- Allocating additional Title XXI funding to cover the Title XXI wait list in 2004.
- Instituting Title XXI-funded Medicaid coverage for infants under age one with incomes from 185 percent to 200 percent of the federal poverty level.
- Enacting comprehensive dental benefits for Healthy Kids enrollees.
- Implementing an expedited eligibility process for the non-Medicaid Florida KidCare program components.
- Making Florida KidCare caseload and expenditure estimates a part of the Social Services Estimating Conference.
- Instituting year-round enrollment in all Florida KidCare program components.
- Enacting mandatory assignment for MediKids after the voluntary choice period ends.
- Changing the Healthy Kids local match policy, including delinking the requirement for local funds as a condition of receiving Title XXI federal funds.
- Receiving Florida's Congressional Delegation support for legislation authorizing the use of federal Title XXI funds for legal immigrant children.
- Implementing a third-party premium payment program for families having difficulty paying their child's premium.
- Authorizing simplified eligibility redeterminations for Medicaid (enacted into law but not implemented).
- Authorizing Medicaid presumptive eligibility for children (Enacted into law but not implemented; later eliminated from law in 2004 legislative session.)
- Aligning Title XIX and Title XXI family and income definitions.

Program Overview

Florida KidCare is the state's children's health insurance program for uninsured children from birth to age 19 who meet income and eligibility requirements. The 1998 Legislature created Florida KidCare in response to the U.S. Congress' passage of Title XXI of the Social Security Act in 1997 — the State Children's Health Insurance Program (SCHIP).

Three state agencies and the Florida Healthy Kids Corporation, a non-profit organization, form the core of the Florida KidCare partnership. The four components are:

- **MediKids** for children ages 1 to 5 (administered by the Agency for Health Care Administration);
- **Florida Healthy Kids** for children ages 5 to 19 (administered by the Florida Healthy Kids Corporation). The Agency for Health Care Administration also contracts with Florida Healthy Kids to conduct Title XXI eligibility determination;
- **Children's Medical Services (CMS) Network** for children with special health care needs from birth to age 19 (administered by the Department of Health for physical health services and the Department of Children and Families for behavioral health), and
- **Medicaid for Children** from birth to age 19 (the Agency for Health Care Administration administers the Medicaid program and the Department of Children and Families determines eligibility for Medicaid).

Figure 1: Florida KidCare Eligibility by Age and Income

Figure 2 on the following page provides an overview of the major Florida KidCare program functions assigned to each Florida KidCare program partner.

Figure 2: Florida KidCare Responsibilities

Funding

The Florida KidCare program is financed with a combination of federal and state funds and family contributions. Federal funding comes from two sources: Medicaid (Title XIX of the Social Security Act) and SCHIP (Title XXI of the Social Security Act).

Medicaid is an entitlement program authorized by Title XIX of the Social Security Act. A State must provide coverage to any individual who meets all of the eligibility requirements. There is no cost sharing for children's Medicaid. The regular match rate for Florida Medicaid is 58.76 percent federal funding to 41.24 percent state funding in federal fiscal year (FFY) 2007.

SCHIP has the most favorable matching rate of the publicly-financed programs, with the federal government contributing 71 cents for every 29 cents Florida invests in children's health insurance.

SCHIP is a non-entitlement program authorized by Title XXI of the Social Security Act. The State has access to a fixed amount of federal funds to extend health insurance benefits to eligible children. In a non-entitlement program, a State may determine how many children to cover and may stop enrollment or modify benefits within broad federal requirements to ensure expenditures do not exceed the Title XXI budget. The SCHIP federal law provides States more flexibility to establish children's health insurance programs tailored to their populations.

SCHIP has the most favorable matching rate of the publicly-financed programs, with the federal government contributing 71 cents for every 29 cents Florida invests in children's health insurance. Florida's match rate for SCHIP is 71.13 percent federal funding to 28.87 percent state funding in FFY 2007.

Tobacco settlement trust funds and general revenue comprise the state's share. Family premium payments are another source of funding for the program; however, family premiums are not eligible for matching with federal Title XXI funds.

In FY 2006-07, the Legislature appropriated approximately $391.2 million for the Title XXI-funded Florida KidCare program components, of which $258.9 million comes from the federal Title XXI allotment, $105.1 million is state share, and $27.2 million is family contributions. The FY 2006-07 Title XXI budget allocation detail is shown in the Appendix.

MediKids, Healthy Kids and part of the CMS Network are funded with Title XXI SCHIP money. Families with incomes at or below 150 percent of the federal poverty level whose children are eligible for one of the Florida KidCare components pay a monthly premium of $15, regardless of the number of children in the family. Families with incomes from 151 percent to 200 percent of the federal poverty level pay a $20 monthly premium. There are also small co-payments for children enrolled in Healthy Kids.

Florida Healthy Kids also serves a small number of non-Title XXI eligible children with a combination of state and local funds and family contributions.

Children under age one with family incomes between 185 percent and 200 percent of the federal poverty level (FPL) are enrolled in the Medicaid program, but their coverage is financed with Title XXI funds and there is no cost sharing. **Table 1** illustrates major differences between Title XIX Medicaid and Title XXI SCHIP.

Table 1: Comparison of Title XIX (Children's Medicaid) and Title XXI (SCHIP) of the Social Security Act

	Title XIX of the Social Security Act (Medicaid)	Title XXI of the Social Security Act (SCHIP)
Description	• Medicaid is the only Title XIX-funded component of Florida KidCare. The CMS Network provides services to Title XIX and Title XXI eligible children with special health care needs • Available to children, families, pregnant women, the elderly and disabled people who meet financial and categorical eligibility requirements • FFY 2006 match rate: 58.76% federal 41.24% state	• SCHIP Title XXI-funded components: o MediKids, ages one through 4 o Healthy Kids, ages five through 18 o CMS Network, special health needs o Medicaid for children under age one (185%-200% FPL) • Available to uninsured children through age 18 who meet eligibility requirements • FFY 2006 match rate: 71.13% federal 28.87% state
Age and Income Eligibility	• 0 to 1: 185% FPL • 1 to 6: 133% FPL • 6 to 19: 100% FPL	• 0 to 1: 186%-200% FPL • 1 to 6: 134%-200% FPL • 6 to 19: 101%-200% FPL
Program Flexibility	• Entitlement: State must cover all individuals who meet financial and categorical eligibility requirements • State must cover certain services at specified levels	• Non-entitlement: State may limit enrollment based on availability of funds • State has more discretion in amount, duration and scope of services offered
Child Eligibility Requirements	• Must meet age and income requirements • May have other health insurance • U.S. citizen or qualified non-citizen • May be a dependent of a state employee eligible for state health insurance benefits • Not in a public institution or institution for mental diseases	• Birth to age 19; above Title XIX Medicaid eligibility levels to 200% FPL ($40,000 for a family of four in 2006) • Uninsured and ineligible for Medicaid • U.S. citizen or qualified non-citizen • Not a dependent of a state employee eligible for state health insurance benefits • Not in a public institution or institution for mental diseases
January 2007 Enrollment ***(as of 12/31/06)**	0 through 5: 516,532 6 through 10: 292,667 11 through 18: 374,614 ***Title XIX Enrollment Total: 1,173,813**	Healthy Kids Title XXI: 170,791 *MediKids: 20,765 CMS Network Title XXI: 11,555 *Title XXI Medicaid for infants: 1,103 **Title XXI Enrollment Total: 204,214**
Services	Comprehensive health benefits, including dental, transportation and waiver services	• MediKids and CMS Network: Medicaid benefits (except waiver services) • Healthy Kids: Comprehensive benefits, including dental
Cost-sharing	None for children	• Families pay $15 or $20 premium per month based on income up to 200% FPL, regardless of the number of children in the family; Healthy Kids also has co-payments • Healthy Kids and MediKids enrollees above 200% FPL pay full premium per child

Federal law gives States three years to spend their SCHIP allotment balances. During the early years of the program, Florida did not expend all of its SCHIP allotment balances, and approximately $119.7 million of federal funds reverted to the federal government and was redistributed to States that used all of their federal funds.

In FFY 2004, because Florida used all of its FFY 2001 SCHIP allotment, the state received SCHIP redistribution funds of approximately $132.6 million. Florida received another allocation of $36.6 million in redistribution funds, due to using all of the State's FFY 2002 SCHIP allotment.

In late 2006, Congress enacted legislation to redistribute existing unspent federal SCHIP funds to some of the States that were projected to face federal funding shortfalls. Florida, as a State that did not use all of its federal funds, will lose $20 million from its federal allocation to help finance the shortfalls in the other States. **Table 2** shows Florida's actual and projected SCHIP federal allotments, expenditures and balances, through Federal Fiscal Year 2009, assuming no additional allotments after Federal Fiscal Year 2007.

Table 2: Florida SCHIP Federal Allotments, Expenditures and Balances (in millions)

Federal Fiscal Year	Beginning Balance	SCHIP Allotment	SCHIP Allotment Reversions	SCHIP Redistribution Funds Earned	Total Revenue	Federal Expenditures	Cash Balance
2006	$408.4	$249.3			$657.7	$210.5	$447.2
2007	$447.2	$296.1	($20)		$743.3	$292.0	$451.3
2008	$451.3	0			$431.3	$321.0	$110.3
2009	$130.3	0			$110.3	$375.7	($265.4)

SCHIP allotments for FFY 2006 are actual and estimated for FFY 2007-FFY 2009 (rounded).
Assumes no additional allotments after FFY 2007.
Source: Agency for Health Care Administration, Estimated State Children's Health Insurance Program Allotment Balances.

Eligibility

To qualify for Florida KidCare ***Title XXI-subsidized coverage***, a child must meet the following eligibility requirements:

- Under age 19;
- Uninsured;
- Not eligible for Medicaid;
- Family income at or below 200 percent of the federal poverty level;
- U.S. citizen or a qualified non-citizen;
- Not the dependent of a public employee eligible for federal or state health insurance benefits; and
- Not in a public institution or in an institution for mental diseases.

State law requirements effective July 1, 2004, specify that a child who is eligible for or covered under a family member's group health plan or employer health plan is ineligible for Florida KidCare, provided the cost of the child's participation does not exceed 5 percent of the family's income.

Children whose family voluntarily cancels their child's coverage within 6 months of an open enrollment period must wait 6 months for subsidized coverage, even if the cost was more than 5 percent of the family's income or the plan's benefit limits were reached (no "good cause" exceptions). While in the waiting period, a family may purchase full pay MediKids or Healthy Kids, depending on the child's age. The state requirements provide an exception for a child whose pre-existing condition prevents coverage in another health insurance plan.

Table 3: 2006 Federal Poverty Level Guidelines (FPL)

Persons in Family or Household	100% of FPL		133% of FPL		200% of FPL	
	Monthly Income	Annual Income	Monthly Income	Annual Income	Monthly Income	Annual Income
1	$817	$9,800	$1,086	$13,034	$1,633	$19,600
2	$1,100	$13,200	$1,463	$17,556	$2,200	$26,400
3	$1,383	$16,600	$1,840	$22,078	$2,767	$33,200
4	$1,667	$20,000	$2,217	$26,600	$3,333	$40,000
5	$1,950	$23,400	$2,594	$31,122	$3,900	$46,800
6	$2,233	$26,800	$2,970	$35,644	$4,467	$53,600
7	$2,517	$30,200	$3,347	$40,166	$5,033	$60,400
8	$2,800	$33,600	$3,724	$44,688	$5,600	$67,200

For each additional person add $3,400
Source: Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849.

In addition to financial eligibility requirements, to qualify for CMS Network services a child must meet clinical eligibility criteria and have a condition that has lasted or is expected to last at least 12 months. To qualify for Behavioral Health Network (BNet) services, a child must be school age and have a serious emotional disturbance. Children who are eligible for BNet services are enrolled in the CMS Network for their physical health care, but receive BNet services from DCF-contracted providers.

The Healthy Kids program covers two other groups of children who do not qualify for federal Title XXI subsidies: (1) children who meet Title XXI financial requirements, but do not qualify on other eligibility requirements (premiums for these children are financed with state and voluntary local contributions and family premiums), and (2) children whose family incomes are above 200 percent of poverty (these families pay the full premium of $108 per child per month for medical coverage only, or $120 per child per month for medical and dental coverage).

State legislation enacted in 2004 limited eligibility for state-funded assistance in Healthy Kids to: (1) legal aliens enrolled as of January 31, 2004, and (2) children who turned age 19 as of March 31, 2004 and were enrolled in Healthy Kids before the Florida KidCare program was implemented.

Starting in July 2006, MediKids began offering a full pay option for children ages 1 to 5 with family incomes above 200 percent of the federal poverty level. The per child rate for MediKids full pay coverage is $159.

Many of the Title XXI eligibility requirements also apply to Title XIX-financed Medicaid. In contrast to Title XXI, however, a child may have other health insurance or be the dependent of a state employee and still qualify for Medicaid provided other eligibility requirements are met. The financial eligibility for children's Medicaid is lower than for the Title XXI-financed portions of Florida KidCare.

In 2006, Congress enacted the Deficit Reduction Act of 2005, which introduced new documentation requirements for Medicaid. Medicaid applicants and beneficiaries must provide proof of citizenship and identity. In Florida and nationally, the new requirements are having a dampening impact not only on Medicaid caseloads, but also on Title XXI caseloads. By federal law, a child cannot be considered for Title XXI-financed coverage if the child is eligible for Medicaid. If a family does not provide citizenship and identity information, the Medicaid eligibility cannot be determined, which results in children being excluded from any type of Florida KidCare coverage.

Benefits

Healthy Kids offers comprehensive health benefits that meet most children's needs. The Florida Healthy Kids Corporation contracts with licensed health plans and health insurers for Healthy Kids enrollees.

Children enrolled in MediKids or the CMS Network receive the Medicaid benefit package, including Medicaid children's dental benefits, but not Medicaid waiver services. MediKids uses Medicaid-enrolled health maintenance organizations and MediPass providers for its service delivery network. The Department of Health contracts with approved providers or integrated care service networks to provide specialized health care services to CMS Network enrollees.

Eligible school age children with serious emotional disturbances or substance abuse problems who are enrolled in the Department of Children and Families' Behavioral Health Network (BNet) are also enrolled in the CMS Network for their physical health care. The Behavioral Health Network covers most Medicaid community mental health services, plus additional specialized services such as treatment planning and review; evaluation services; case management; family support; respite; and residential, rehabilitative and day treatment services. Services are provided through a statewide network of managed behavioral health care organizations and private- and state-funded mental health and substance abuse treatment providers.

Enrollment

In state Fiscal Year 2006-2007, Florida KidCare enrollment began to grow again, but remains below the highest enrollment, which occurred in April, 2004. The University of Florida's Institute for Child Health Policy conducts the annual Florida KidCare evaluation. In FY 2005-06, there were 139,387 applications processed, representing 267,422 children. Slightly more than one half (51 percent) became enrolled in one of the Florida KidCare program components, compared to 69 percent becoming enrolled in FY 2003-04, the year before additional documentation and active renewal requirements were implemented. According to the Institute's research, 63 percent of the children leaving the program become uninsured (presentation to House Healthy Families Committee, January 9, 2007).

Figure 3: Percent of Florida KidCare Applicants Enrolled

Source: Institute for Child Health Policy presentation to House Healthy Families Committee, January 9, 2007

Table 4 shows Florida KidCare enrollment by program component for January 2006 and January 2007 and the FY 2006-07 appropriated average monthly enrollment targets.

From January 2006 to January 2007, total Florida KidCare enrollment decreased 4 percent, from 1,465,678 children in January 2006 to 1,404,173 in January 2007, primarily due to declining Medicaid enrollment.

From January 2006 to January 2007, enrollment for Title XXI-subsidized children increased by 10 percent, from 186,080 to 204,214. The CMS Network experienced a 53 percent increase during this period. Aggressive retention measures instituted in FY 2005-06 continue, resulting in the CMS Network having the lowest attrition rate due to non-compliance with renewal requirements.

Table 4: Comparison of Florida KidCare Enrollment, January 2006 and January 2007

Program Component	FY 2006-07 Average Monthly Enrollment Target	January 2007 Enrollment	January 2006 Enrollment	% Change from January 2006 to January 2007
Title XXI Enrollment				
Healthy Kids	195,867	170,791	160,475	6%
MediKids	21,000	20,765	16,812	24%
CMS Network	11,292	11,555	7,564	53%
Medicaid<Age 1 (185%-200% FPL)		1,103	1,229	-10%
Title XXI Total	**253,959**	**204214**	**186,080**	**10%**
Healthy Kids Non-Title XXI state/local subsidized	1,926	2,715	4,005	-32%
Healthy Kids Full Pay	23,874	22,715	22,356	2%
MediKids Full Pay		716	0	Not Applicable; started July, 2006
Title XIX Medicaid Enrollment		1,173,813	1,253,237	-6%
Florida KidCare Total Enrollment		**1,404,173**	**1,465,678**	**-4%**

Source: Agency for Health Care Administration Florida KidCare Monthly Enrollment Reports

Of the Title XXI-financed program components, Healthy Kids represents 84 percent of the enrollment, followed by MediKids with 10 percent, the CMS Network (including children enrolled in the BNet) with 6 percent, and Title XXI-funded Medicaid for infants under age one with 1 percent.

Healthy Kids provides coverage with state and voluntary local contributions for a limited number of children who do not qualify for Title XXI subsidies. Of the total 196,221 Healthy Kids enrollees in January 2007, 87 percent are Title XXI-subsidized, 12 percent have family incomes over 200 percent of the federal poverty level and pay the full per child premium, and 1 percent is Title XXI-ineligible non-citizens or 19-year-olds.

Figure 4 shows the trend for Florida KidCare total enrollment over time.

Figure 5 shows Title XXI Florida KidCare enrollment trends over time by program component.

Figure 4: Florida KidCare Total Enrollment ***(Including Title XIX Medicaid for Children)***

**Medicaid and MediKids enrollment as of 12/31/06*

Figure 5: Florida KidCare Title XXI-Funded Enrollment by Component

**MediKids and Medicaid enrollment is as of 12/31/06*
Medicaid for Teens ended 9/30/02; Medicaid for Infants <1 only

Programmatic Changes

Throughout FY 2003-04, FY 2004-05, FY 2005-06, and FY 2006-07 the Legislature and the Florida KidCare partner agencies instituted policy and programmatic measures to address budget constraints, potential concerns about the availability and amount of SCHIP federal funds in future years, and program integrity.

Figure 6 is an overview of major program changes and Title XXI enrollment from FY 2002-03 through January 2007. Title XXI enrollment was at its highest level of 336,689 children in April 2004, as a result of legislative funding for the wait list that had accumulated during FY 2003-04. Enrollment began declining from that point to December 2004, when disenrollments for non-compliance with renewal documentation and non-payment of premiums occurred after a three-month grace period for hurricane relief.

As a result of open enrollment in January 2005, about half of the applicants became enrolled in one of the Florida KidCare program components. Following legislative action to reinstate year-round enrollment, the program re-opened enrollment in June 2005.

Figure 6: Florida KidCare Title XXI Enrollment and Major Program Changes

Subsequent to changes during the 2006 Legislative session, in July 2006, the MediKids program implemented a full pay buy-in option for children ages 1 to 5 with family incomes above 200 percent of the federal poverty level.

The Legislature also allocated $1 million in non-recurring general revenue to the Florida Healthy Kids Corporation for Florida KidCare community-based marketing and outreach matching grants. The corporation awarded grants to 15 organizations, funded at about $961,000. **Figure 7** shows the distribution of grantees around the state.

Figure 7: Florida KidCare Community-Based Marketing and Outreach Matching Grants

Source: Florida KidCare Enrollment, Senate Interim Project #2007-372, January 11, 2007.

Recommendations and Discussion

The council's 2007 recommendations focus on strategies to accomplish the following objectives: (1) reduce child uninsurance in Florida by increasing enrollment and retention; (2) simplify the program's administration; (3) remove barriers and promote seamlessness when children move between Florida KidCare program components; (4) increase statewide awareness about the Florida KidCare program; and (5) ensure that sufficient state and federal funding is allocated to support coverage for more uninsured children.

The council's federal recommendations also identify key issues for Florida's children that require federal congressional action. SCHIP federal reauthorization and increased federal funding for Florida is a critical need. Other federal recommendations address opportunities for more uninsured children to participate in Title XXI-funded coverage.

At the request of Senate staff, the members prioritized recommendations to assist staff with their interim project on Florida KidCare. Within each category, the recommendations are presented in the order in which they were prioritized for the Senate staff, but they do not reflect a prioritization for this report. A majority of members indicated that the recommendations should be taken as a whole to improve the Florida KidCare program.

State and Administrative Recommendations

Role of KidCare in Addressing Uninsured Children

Fully fund the Florida KidCare program, including its annualization needs and projected growth needs in order to maximize the use of Florida's SCHIP federal funds and include all eligible uninsured children. (18 yes, 0 no, 0 abstentions)

About 35 percent of Florida's 4 million children under age 19 currently are enrolled in one of the Florida KidCare program components, primarily in Medicaid. Nationally and in Florida, however, child uninsurance is rising again after several years of declining.

According to the U.S. Census, an estimated 494,000 Florida children with family incomes at or below 200 percent of the federal poverty level were uninsured in 2005.

The Campaign for Children's Health puts Florida 3rd in the nation with the largest number of uninsured children (almost 719,000, including all income levels), and 2nd with the highest percentage of uninsured children (17 percent).

Florida continues to have a large unspent balance of federal Title XXI funds. After accounting for projected expenditures this year, the state will have a remaining federal balance of about $450 million.

The council recommends that the state further increase its investment in children's health by appropriating the necessary state funds to maximize its use of federal funds and cover more uninsured children.

Increase Medicaid reimbursement for physician services at least to Medicare levels for services rendered to children ages 0 to 21 in order to ensure an increase in access to care. (18 yes, 0 no, 0 abstentions)

Increase fees for children's dental services in all of the Florida KidCare program components in order to ensure an increase in access to care. (18 yes, 0 no, 0 abstentions)

Low physician participation in Medicaid has a negative effect on enrollee access to medical care. The Center for Studying Health System Change reports that about one-fifth of physicians reported accepting no new Medicaid patients in 2004-05, a rate six times higher than for Medicare patients and five times higher than for privately insured patients.

The Center further reports that care of Medicaid patients is becoming increasingly concentrated among a smaller proportion of physicians practicing in large groups, hospitals, academic medical and community health centers, with low payment rates and high administrative costs contributing to decreased participation among physicians in solo and small group practices (Peter Cunningham and Jessica May, *Medicaid Patients Increasingly Concentrated Among Physicians*, Results from the Community Tracking Study, No. 16, August 2006).

Medicaid patients' access to physician services, especially specialty services, is problematic in Florida. Low Medicaid reimbursement rates affect providers' willingness to accept patients, which in turn affects patients' access to care.

Approximately 44 percent of Florida Medicaid physician service expenditures are for children. The 2004 Legislature appropriated funding to increase Medicaid reimbursement for certain pediatric specialty providers by 24 percent. The fee increases applied to cardiology, orthopedics, neurology, neurosurgery and oncology. Many Southern states have raised their Medicaid reimbursement rates to Medicare or near-Medicare levels (e.g., Alabama, Georgia, Mississippi and North Carolina).

Research in Florida and nationally identified low reimbursement rates as a significant deterrent to dentists' participation in the Medicaid program. In Florida, Medicaid payments for children's dental services have remained unchanged for many years. Access to children's dental services is a recognized critical need; untreated dental problems can lead to serious health conditions and hospitalizations.

The council recommendations to increase physician and dental services would help providers cover the cost of serving children in Florida KidCare. More importantly, it would help ensure that children continue to have access to these essential components of the health care delivery system.

Implement the state option Family Opportunity Act pursuant to the Deficit Reduction Act of 2005. (18 yes, 0 no, 0 abstentions)

The Family Opportunity Act, enacted as part of the Deficit Reduction Act of 2005, permits States to offer Medicaid services as an optional eligibility category to families with incomes up to 300 percent of the federal poverty level ($60,000 for a family of four) and who have children with disabilities that meet the Supplemental Security Income (SSI) definition of disability, or have the potential to meet this definition if appropriate health care services are not provided. Federal financial participation is at each State's regular Medicaid matching rate.

Enrollee participation is phased in over a three-year period based on the child's age starting with children up to age 6 in 2007, and phased in to children up to age 19 in 2009.

If an employer of a parent whose child would be eligible offers family coverage under a

group health plan and the employer contributes at least 50 percent of the total cost of annual premiums, the parent is required to apply for, enroll in, and pay premiums for such coverage as a condition of the child's eligibility for medical assistance under the Family Opportunity Act.

If the parent obtains coverage for the disabled child through the employer's group health plan, the State is required to reduce the Family Opportunity Act coverage premium in an amount that reasonably reflects the parent's premium contribution for the disabled child's private coverage.

The Act authorizes States to impose monthly premiums on a sliding scale based on family income:

- For a disabled child whose family income does not exceed 200 percent of the federal poverty level, the aggregate premium amount of the Family Opportunity Act coverage plus any premium the parent is required to pay for family coverage and other cost-sharing charges must not exceed 5 percent of the family's income.
- For a disabled child whose family income is between 200 percent and 300 percent of the federal poverty level, the aggregate premium amount and other cost-sharing charges must not exceed 7.5 percent of the family's income.
- A State may waive the premium in cases where it determines requiring a premium payment would present a hardship.

Currently, parents of children who would meet the SSI disability definition but whose family income exceeds 200 percent of the federal poverty level may purchase full pay MediKids or full pay Healthy Kids coverage, depending on the child's age. The monthly per child rate is $159 for MediKids and $108 or $120 for Healthy Kids, depending on whether the family elects to have dental coverage. While the benefits in these plans are more extensive than many private plans, they are not designed to serve children with special health care needs. Moreover, the premiums are based on a primarily healthy population. By including children with more extensive health care needs in the mix, the overall premiums in these programs may be increased.

The CMS Network's subsidized premium rate for FY 2006-07 is almost $565 per member, per month. It would not be financially feasible for most families if a CMS Network full pay option was to be developed.

Cost of coverage is one problem facing families of children with special health care needs, but the adequacy of the coverage is another problem that is unique to populations with more extensive health care needs. Children whose families have private coverage but it is inadequate to meet the child's health care needs, do not currently have an option to purchase additional coverage through Florida KidCare. Implementation of the Family Opportunity Act would provide these families with a way to purchase affordable and adequate health care for their child with special health needs.

Allow coverage in all of the Florida KidCare program components of children with family incomes up to 200% of the federal poverty level not eligible for Title XIX or Title XXI, using only state and local funds with no federal match. (18 yes, 0 no, 0 abstentions)

Legislation enacted in 2004 limits eligibility for Healthy Kids state-funded assistance to:

- Legal aliens enrolled in Healthy Kids as of January 31, 2004;
- Children who turned age 19 as of March 31, 2004, provided they were receiving Healthy Kids benefits before Florida KidCare was enacted (repealed March 31, 2005); and
- State employee dependents who were enrolled in Healthy Kids as of January 31, 2004; their eligibility ended January 1, 2005.

The council's recommendation would allow Healthy Kids, MediKids and the CMS Network

to offer state and locally funded coverage to children with family incomes up to 200 percent of the federal poverty level but do not qualify for Title XIX or Title XXI subsidies. Because no federal funds are involved, eligibility also could be expanded to include children who are underinsured or for whom private health insurance benefits are not adequate to meet their health care needs.

Financing for the initiative would include families paying the same monthly premium as Title XXI-financed enrollees. The state would cover 71 percent of the remaining cost and the local share would be 29 percent, which is the same proportion of investment between the federal government and Florida for the Title XXI-funded Florida KidCare program.

Implement a medical income disregard for children with catastrophic illnesses who would otherwise qualify for Title XXI subsidies. (18 yes, 0 no, 0 abstentions)

As it has recommended in previous years, the council recommends implementing a medical income disregard, which would allow children with special health care needs who would qualify for subsidies except for income, to be enrolled in Title XXI-funded health insurance.

Authorizing the Florida KidCare program to include special needs children who currently receive services through state-only sources and MediKids and Healthy Kids full pay would provide a mechanism for state funds to draw down federal Title XXI revenue at a roughly 3 to 1 match, maximizing federal funds, ensuring more of Florida's federal Title XXI allotment is used for Florida children, and assisting families.

Program Simplification and Seamless Coverage

Create a single administration for marketing, eligibility, contracting, quality assurance, and financing. (20 yes, 1 no, 2 abstentions)

Florida has one of the most complicated children's health insurance programs in the country.

Each program component has different eligibility criteria and administrative oversight. Different aspects of eligibility determination is spread among the Florida KidCare partner agencies as well:

- Department of Children and Families determines eligibility for Title XIX-financed Medicaid
- Florida Healthy Kids determines eligibility for non-Medicaid Florida KidCare
- Department of Health determines clinical eligibility for the Children's Medical Services Network

Four different computer systems are engaged in some part of the Florida KidCare process:

- Agency for Health Care Administration: Florida Medicaid Management Information System (FMMIS)
- Department of Children and Families: FLORIDA system
- Florida Healthy Kids: Child Health Administration System (CHAS); operated and maintained by the corporation's current third-party administrator
- Department of Health: Children's Medical Services information system, interfaced with Department of Children and Families' database for Behavioral Health Network eligible children.

Quality assurance standards also vary among the program components, as do the contractual relationships with different health care providers.

Each of the partners also responds to family and provider complaints about the program,

so there is no single entity from which to collect this information. A lack of administrative rules further contributes to confusion about program policies and procedures.

The current structure was the result of using existing programs to implement the State Children's Health Insurance Program quickly in 1998. A 2006 Florida Senate Interim Project Report on Florida KidCare states:

"Almost ten years after KidCare's creation, some argue that this structure is no longer viable and can be simplified. These stakeholders state that the program would be more efficient if there would be greater accountability by consolidating as many functions as possible under as few administrative entities as possible. Others state that most problems have been addressed and that the various entities bring unique skills to the administration of the program. They also argue that any consolidation would cause unnecessary confusion in the eyes of the public, resulting in instability and enrollment just as enrollment trends are beginning to move upward. What most stakeholders do agree with is that there is no clear "leader" for the KidCare program and that there are times where the various administrative entities act in their own interest, rather than the interest of the program as a whole." (Florida Senate Interim Project Report 2007-131, October 2006).

For several years the council has recommended program consolidation, not only to improve it for children, families and providers, but also to make it more accountable and transparent to the public in how it operates.

Reinstate and implement presumptive eligibility for all Florida KidCare program components. (22 yes, 0 no, 1 abstention)

The Legislature enacted presumptive eligibility for children into state law in 2000, but the provision was never implemented due to budgetary concerns and the 2004 Legislature eliminated the language from the Florida KidCare Act.

Presumptive eligibility allows qualified health providers or agencies to grant short-term eligibility to children, enabling them to receive health services for which providers are compensated while a formal eligibility determination is made.

Although there have been improvements in the amount of time from application to enrollment, there are still gaps during which families may delay seeking care for their children due to costs. Benefits of implementing presumptive eligibility include improved health outcomes for children due to removing cost barriers to obtaining needed care early, improved access to preventive and primary services, and lower uncompensated care costs.

Revise the earned and unearned income documentation requirements to first use electronic verification of income and then require other written income documentation only if the electronic verification does not substantiate the family's income.
(22 yes, 0 no, 0 abstentions)

Statutory language enacted in 2004 specified new income documentation requirements that proof of family income must be supported by copies of any federal income tax returns for the prior year, any wages and earnings statements (W-2 forms), *and* any other appropriate documents (House Bill 1843).

During a December 2004 special session, the Legislature amended the requirements to require proof of family income "which must include a copy of the applicant's most recent federal income tax return. In the absence of a federal income tax return, an applicant may submit wages and earnings statements (pay stubs), W-2 forms, *or* other appropriate documents." (Senate Bill 28-A).

The December changes reduced the number of children whose coverage was canceled for not providing all three earned income documents. Families, providers and child advocates acknowledged the Legislature's willingness to correct the situation.

The change reduced the amount of earned income documentation each working parent or guardian must submit as new applicants and for redetermining current enrollees' eligibility. It is still, however, a paper requirement that does not take advantage of less costly electronic verification methods.

Florida KidCare applicants also must submit written documents to verify *unearned income*, such as child support, Social Security benefits, Supplemental Security Income, unemployment benefits, Veteran's benefits, and worker's compensation. Families that receive unearned income are required to submit award letters substantiating this income in addition to earned income documentation.

According to data provided to the Healthy Kids Eligibility Improvement Subcommittee, child support and Social Security account for 87 percent of reported unearned income. **Table 5** shows application and enrollment information over time. After implementation of the documentation requirements, the percentage of children who became enrolled dropped to only about half of those who applied.

Table 5: Application and Enrollment Information, FY 2001-02 through FY 2005-06

Description	2001-02	2002-03	2003-04	2004-05	2005-06
Number of Applications FHKC Received	176,647	168,647	89,401	139,158	139,387
Number of Children on the Applications	297,994	274,087	150,490	267,929	267,422
Percent of children approved for non-Medicaid Florida KidCare (Healthy Kids, MediKids, CMS Network)	45.4%	30.2%	30.4%	20.8%	19.4%
Percent of Children DCF approved for Medicaid	37.0%	42.0%	38.9%	31.2%	27.3%
Percent of children rejected for other health insurance or over age 19	8.2%	5.6%	4.8%	4.3%	4.3%
Percent of children not directly enrolled in Florida KidCare or referred to DCF for Medicaid determination[a]	9.4%	22.2%	25.9%	43.7%	49%

[a]*Includes pending; waiting for additional information; and rejected for other reasons.*
Source: Florida KidCare Program Evaluation Reports, Prepared by the Institute for Child Health Policy, University of Florida, under contract to the Agency for Health Care Administration

In a December 2005 operational audit of the Florida KidCare program, the Auditor General made several findings relating to income documentation. Recommendations included enhancing policies and procedures related to income calculations, increased training, and improving the accuracy of the application scanning process because copied paper documents can be unclear and difficult to decipher, which can increase errors.

Collecting and processing additional documents is costly. Healthy Kids' eligibility determination and administrative costs almost doubled to $5.82 per member, per month after implementation of the new requirements. As of July 2006, the rate increased by 8.4 percent to $6.31 per member, per month.

Use of electronic data exchanges, in lieu of paper documents, could help lower administrative cost and still ensure program integrity. The Florida Department of Law Enforcement maintains an electronic database of wages and earnings. Through an agreement between the state agencies, access to this database to verify income electronically would further reduce paperwork for families and administrative costs for the state. One potential disadvantage of this approach is that the wage data on file is not an accurate reflection of the family's current income, such as pay stubs for the last 4

weeks. When the Legislature changed the income verification requirements in 2004, however, it was noted by some legislators that the most recent federal income tax return is the preferred document for income verification. In the case of families applying for Florida KidCare, this information may be more than one year out of date.

The Department of Children and Families relies on a number of data exchanges to verify income for Medicaid eligibility, and requests other types of income verification as a secondary measure. Many sources of unearned income also may be verified electronically.

The Florida Healthy Kids Corporation revised its web site to create web-based tools that help families determine what documents they need to submit. The corporation also launched an on-line application in early 2006 and online renewal work is in progress. While these are important initiatives to aid families, the requirement to continue submitting paper documents creates barriers for some families in getting and keeping their children's coverage.

When the Healthy Kids Corporation reconvened its Eligibility Improvement Subcommittee, one of the charges to the Florida KidCare partner agencies was to identify all potential forms of data exchanges and the agreements that would be needed to allow the Florida Healthy Kids Corporation to use them before requiring paper documents.

The council recommends using electronic verification of earned and unearned income before seeking other written income documentation from a family, and then requiring other written income documentation only if the electronic verification does not substantiate the family's income. Implementation of this recommendation would balance the need to ensure program integrity with removing administrative paperwork barriers that prevent new eligible children from enrolling and currently enrolled eligible children from keeping their Florida KidCare coverage.

Adopt a seamless system for children with special health care needs by moving CMS Network (CMSN) eligible children with family incomes up to 200% of the federal poverty level to Medicaid using Title XXI funding. (18 yes, 0 no, 2 abstentions)

Children enrolled in the CMS Network have the most serious and complex health conditions. State law defines children with special health care needs as "those children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and who also require health care and related services of a type or amount beyond that which is generally required by children." (s. 391.021, F.S.)

To meet clinical eligibility requirements for the CMS Network, a child must have a qualifying condition that has lasted or is expected to last at least 12 months. Examples of qualifying conditions include congenital, genetic and chronic conditions, such as cancer, diabetes, conditions requiring transplant services, and severe emotional disturbances.

Three reasons account for approximately 75 percent of cancellations from the Title XXI-financed CMS Network:

(1) late or no premium payment (60-day lockout imposed);

(2) incomplete or non-compliance with renewal requirements, and

(3) child became Medicaid eligible.

When these children lose coverage, their health may be compromised and continuity of care is disrupted. Services they receive during the period of uninsurance may result in uncompensated care for providers, or additional state expenditures in the form of 100 percent state funds to cover an emergency medical condition only, or Medically Needy share of cost, which has a lower federal financial participation rate than Title XXI.

There is a great deal of movement between Title XIX Medicaid and Title XXI eligibility for this population, and the transitions are not always smooth, even though the child may

remain clinically eligible for the CMS Network. Breaks in coverage of one month or more are common when a child loses Medicaid coverage and needs to be transferred to Title XXI-funded enrollment.

The federal Title XXI law gives States broad discretion to design their programs to meet their populations' needs. Although originally designed as part of the separate state children's health insurance program in Florida, children enrolled in the Title XXI-funded CMS Network have health conditions that are not conducive to the traditional health insurance model. Their pre-existing health conditions have either made a large number of them uninsurable in the commercial health insurance market, or the cost is too high and the benefits are not sufficient to meet their needs.

The CMS Network serves Title XIX-funded Medicaid and Title XXI-funded SCHIP children with special health care needs. Most of the enrollees have Medicaid. Integrating the Title XXI-funded CMS Network enrollees with incomes up to 200 percent of the poverty level into the Medicaid-funded portion of the CMS Network could be accomplished with Title XXI funding, like the funding for Medicaid for infants. The benefit structure and the Title XXI monthly per child premium AHCA pays to the Department of Health for the CMS Network and to the Department of Children and Families (for BNet children) could be retained.

The CMS Network Advisory Council recommended, and the KidCare Coordinating Council concurred, that in moving the Title XXI-funded CMS Network children to Medicaid with Title XXI funding, the CMS Network care coordination and statewide system of care should be maintained as the service delivery system for children with special health care needs.

Increase Medicaid eligibility for children ages 5 through 18 to 133% of the federal poverty level. (16 yes, 0 no, 3 abstentions)

Florida Medicaid currently finances coverage for children ages 1 to 6 with family incomes up to 133 percent of the federal poverty level ($26,600 for a family of four in 2006). At ages 6 to 19, Title XIX-financed Medicaid is available for children in families up to 100 percent of the federal poverty level, or $20,000 for a family of four in 2006.

A child's transition from Title XIX-funded Medicaid to Title XXI-funded Florida KidCare coverage is a significant problem in Florida KidCare.

By increasing Medicaid eligibility for children from ages 1 to 19 with incomes up to 133 percent of the federal poverty level, some of the transition issue could be alleviated, because transfers would only be based on income, not the child's age. This recommendation alone would not totally resolve the transition problem, but coupled with other recommendations such as accepting DCF income and other eligibility information for Title XXI eligibility, fewer children would lose coverage due to changes in their eligibility status from Medicaid to another Florida KidCare program component.

Promote program stability. (19 yes, 0 no, 0 abstentions)

The Florida KidCare program has undergone significant changes in the last few years, which have resulted in declining enrollment and consumer confusion about the program.

Families remain satisfied with the Florida KidCare program's services and health care providers once they get enrolled, but they are dissatisfied with the amount of paperwork they are required to provide in order to get and keep health care for their children. The council continues to recommend and endorse measures that will make the process easier for families and increase enrollment and retention. It also recognizes that actions that would result in further confusion and dissatisfaction should be avoided. However,

the council members directed staff to include in this annual report that initiating measures to improve the program for Florida's children and families should not be sacrificed for the sake of ensuring "program stability".

Improvements should be made, which would not only result in long-term program stability, but also in more coverage for uninsured children.

Retention and Transition

To promote smooth transitions between Florida KidCare program components and prevent breaks in coverage, when a child has been determined as over-income for Medicaid by the Department of Children and Families (DCF), accept the income and other necessary eligibility information electronically from DCF for Title XXI eligibility determination. (18 yes, 0 no, 0 abstentions)

Section 409.913, F.S., defines the Florida KidCare program to include health benefits coverage provided to children through: (1) Medicaid, (2) MediKids, (3) the Florida Healthy Kids Corporation, (4) certain employer-sponsored group health insurance plans, and (5) the Children's Medical Services Network. The Department of Children and Families (DCF) determines eligibility for Medicaid, and the Florida Healthy Kids Corporation determines eligibility for the Title XXI-funded Florida KidCare components.

Currently, the DCF sends a weekly electronic file to Florida Healthy Kids containing information for children who lost Medicaid eligibility due to income. The Healthy Kids third-party administrator checks its Children's Health Administration System (CHAS) to determine if any of the children on the file from DCF are "known" to CHAS. If a child's name is found on the CHAS system, the child's account is set to pending and the family receives a letter indicating what information is needed to activate the premium-based Florida KidCare coverage. If it has been more than 120 days since the child was last enrolled in the non-Medicaid Florida KidCare program, then the family will have to supply income documentation (earned and unearned) to substantiate their income.

If a family never applied on the mail-in application to the Florida Healthy Kids Corporation, but instead applied through DCF, then the child's name will not be "known" to the CHAS computer system. In these cases, the family will receive a Florida KidCare application with a letter inviting the family to apply for Florida KidCare. The family has to complete the application, including all documentation requirements.

From August 1, 2005 to November 30, 2005, the DCF referred 20,175 children to Healthy Kids. About 20 percent of these children were "known" to the CHAS system. Of the 20,175 children — 1,080 or 5.35 percent — were approved for coverage in one of the other Florida KidCare program components (Eligibility Improvement Subcommittee Meeting materials, December 16, 2005).

The process has improved since 2005, but successful transitions from Medicaid to another Florida KidCare component without a significant break in coverage are still too low.

According to a Senate Interim Project report, between January and June 2006, DCF referred 42,994 children who had lost Medicaid eligibility due to age or income. Most of these children –almost 92 percent – were already in the CHAS system. Of those previously "known to the system," 41 percent were approved for Title XXI-funded coverage (Florida Senate Interim Project Report 2007-131, October 2006). Healthy Kids staff indicated that this is about the same percentage as newly enrolled children who applied for the program (Healthy Kids partner update at the KidCare Coordinating Council, December 1, 2006).

The issue of transitions from Medicaid to another Florida KidCare component without a break in coverage is a long-standing concern, and was scheduled to be resolved through

new system updates by November 2006 (Florida Senate Interim Project Report 2007-131, October 2006). At the December 1, 2006, KidCare Coordinating Council meeting, however, Healthy Kids staff reported that, due to the award of the corporation's third party administrator contract, this change would likely not occur until 2008 when the new vendor is in place. Without changes, as much as 60 percent of children who lose Medicaid due to income or age that DCF refers to Healthy Kids could either become uninsured or have lengthy breaks in their coverage.

All enrollees in Florida KidCare should receive the same retention efforts.
(18 yes, 0 no, 0 abstentions)

According to the University of Florida's Institute for Child Health Policy, in FY 2005-06, about 13 percent of children were disenrolled at renewal time. Children ages 15 through 17 and children in lower income families are more likely to lose Florida KidCare coverage and become uninsured (Institute for Child Health Policy presentation to House Healthy Families Committee, January 9, 2007).

Currently, the Florida Healthy Kids contractor sends non-Medicaid families pre-populated renewal notices 60 days in advance of a child's renewal date and follows up with letters about missing renewal information to non-Medicaid Florida KidCare enrollees. If a family returns any piece of required information to indicate continued interest in maintaining a child's coverage, they receive an additional 30 days to submit the remaining missing information. On-line renewal is in progress, but has not been implemented as of January 2007.

In early 2005, the CMS Network began disseminating "Florida KidCare Renewal Organizers" to its families to help them understand all of the information required for renewal. Retention among CMS Network enrollees is the highest of the Florida KidCare program components. This is primarily because parents whose children have serious health care needs are motivated to keep coverage, but also because the CMS care coordinators stationed throughout Florida have relationships with the families and serve as advocates to help them enroll and keep coverage.

The Children's Medical Services program continues to provide renewal organizers to CMS Network families, but due to budget constraints, is unable to print the documents for other families. The production files have been made available to allow other entities to produce the renewal organizers at their expense.

CMS staff also has developed a "Status Check" process with Florida Healthy Kids to identify and resolve problems CMS families may be having with enrolling in the program, retaining their children's coverage, or reinstating coverage after a cancellation. CMS status checks to Healthy Kids have continued to increase, with requests ranging from 600 to 775 per month.

Efforts to help families retain coverage are less expensive than having to find and re-enroll them at a later time. Retention–helping families whose children are already enrolled in Florida KidCare keep their coverage–is a natural component of outreach. The $1 million of non-recurring funds the Legislature allocated to Healthy Kids for Florida KidCare community-based outreach and marketing activities in FY 2006-07 has been designated for identifying and helping new applicants enroll in the program–not on helping existing children keep their coverage.

As a result of new federal citizenship and identity documentation requirements for Medicaid, additional retention efforts are also needed for children whose Florida KidCare coverage is Title XIX-financed.

The council recommends that all children should receive effective retention efforts to ensure that eligible children remain enrolled in the program.

Outreach and Marketing Activities

Restore and fund Florida KidCare community coordination, retention efforts, and health and family education and utilization functions to reach uninsured children. In addition, provide funding for marketing and education for hard-to-reach and special populations. Evaluate marketing efforts to measure value received for expenditures.
(18 yes, 0 no, 0 abstentions)

Marketing should be conducted for the entire Florida KidCare program. Family advocates should be included in the planning, development and implementation of the marketing messages and open enrollment announcements. (18 yes, 0 no, 0 abstentions)

Before state and federal funding was eliminated in 2003, the Florida KidCare Outreach Program was an award-winning program, which was recognized by the federal Centers for Medicare and Medicaid Services (formerly HCFA) and was a model for other states when they were starting up their SCHIP programs. The program financed 17 regional projects located throughout Florida. These were grassroots organizations that conducted the work of recruiting families to enroll, and providers and others organizations to become partners in the outreach and education effort. Volunteers and community organizations throughout Florida supplemented the state's outreach efforts.

In the last year before the funding was eliminated, the total budget was about $4 million, most of which was federal funds. Before its termination, some of the major functions the Outreach Program supported included:

- **17 Regional Outreach Projects** charged with recruiting and training community partners; conducting special application, enrollment and projects; and using targeted outreach to special populations. In the last year of operation, all efforts at both the state and local level focused on "institutionalizing" Florida KidCare outreach at the local level. Organizations that could continue the activities without federal and state resources were urged to make outreach part of their regular course of doing business.
- **Statewide Multi-Media Buys in English, Spanish and Haitian Creole:** TV ads were rolled out in stages across the state to prevent backlogs at the call center; the program also paid for and placed radio ads, bus cards and billboards.
- **Information and Materials:** Florida KidCare applications were provided to anyone who requested them. Brochures, posters, promotional items, health information booklets, and materials targeted special populations. Currently, there is not a budget for printing Florida KidCare applications, and organizations that want to distribute applications must pay printing and shipping costs.
- **Family Advocacy:** Helping families "navigate" the Florida KidCare system was a significant function, which is now spread out across the various partner agencies. It involved trouble-shooting and direct hands-on resolution of account and coverage problems with families. The information gathered as a result of this activity helped the partner agencies to diagnose and fix systemic administrative problems.
- **Data Driven Marketing Research:** Quantitative and qualitative analyses were conducted to ensure materials were culturally appropriate, met the needs of people with low literacy levels, and resonated with the populations. Empirical data measures were employed to determine which strategies were most effective. All materials were focus grouped with diverse groups of parents in different languages; participants included those with children enrolled and those with children who were potentially eligible.

- **County Level Data Reporting:** Monthly enrollment trends at the county level, outreach reports (effectiveness of various measures), and uninsurance information, was posted on the Florida KidCare web site. The monthly reports allowed the regional projects to adapt their strategies in real-time to focus on those that appeared to be having the best return on investment. The KidCare application also included "tracking numbers" and a section that asked: "How did you learn about the KidCare Program?" to help identify which strategies were most effective in motivating families to apply.

- **Statewide Training and Technical Assistance:** As part of this effort, the regional project staff would recruit potential "Florida KidCare Partners" by visiting them in their offices; giving presentations about the program; attending job fairs, health fairs and other large events where people with uninsured children would be present; and conducting "application sign-up" events to gather interested families and help them fill out the application form. The partnerships were extensive and very effective because trusted community members were available to cultivate relationships and ensure partners had the tools needed to remain committed to the program.

- **Florida KidCare Partner Agency Collaboration:** Outreach staff served as a linchpin to facilitate communication and cooperation among the KidCare partner agencies and fostered the relationship with the Robert Wood Johnson (RWJ) Foundation Covering Kids Project located at the University of South Florida Lawton and Rhea Chiles Center for Health Mothers and Babies. This is another area where Florida was recognized as a leader; in many states, the RWJ projects were viewed as outsiders by the state agencies, and the relationships were poor. Florida was used as an example of how these initiatives were intended to work. The Chiles Center still receives inquiries from other states about how they have been able to maintain their relationship with the agencies and provide valuable input into improving the Florida KidCare program.

Evaluations of these outreach activities consistently found that families learned about the Florida KidCare program differently, depending on their children's ages and needs. **Table 6** summarizes the top three information sources by program component of how families learned about the Florida KidCare program during FY 2005-06.

Current Activities. The 2006 Florida Legislature authorized $1 million in non-recurring general revenue funds to the Florida Healthy Kids Corporation for a Florida KidCare community-based marketing and outreach matching grant program. The corporation issued awards in two phases during the fall of 2006, with a total of 15 awards being made to community organizations.

Beginning in January 2007, the corporation's board of directors authorized a Healthy Kids marketing initiative to be conducted jointly with the Florida Association of Health Plans and the Florida Broadcasters Association. As part of its initiative, the Florida Healthy Kids Corporation will use statewide testimonials from enrolled families (Healthy Kids presentation to House Healthy Families Committee, January 9, 2007).

While these initiatives should have a positive impact on increasing enrollment, with nearly half a million uninsured but potentially eligible children in Florida, the council recommends sufficient funding to restore a full-fledged outreach initiative that includes family advocates. Additional special emphasis on hard-to-reach populations is recommended as well, because Hispanic and African American children are disproportionately represented among the uninsured.

Table 6: How Families Learned about Florida KidCare by Top Three Information Sources and Program Component, State FY 2005-06

Program Component	Number 1	Number 2	Number 3
MediKids	Family/Friend	Doctor/Provider	Kid's School
Healthy Kids	Kid's School	Family/Friend	Doctor/Provider
CMS Network	Doctor/Provider	Family/Friend	Kid's School
Medicaid	Family/Friend	Kid's School	Doctor/Provider

Source: Florida KidCare Program Evaluation Report for 2006, January 2007, Draft Report, Institute for Child Health Policy, University of Florida

To avoid consumer confusion, the council also recommends marketing the *Florida KidCare Program*, which is the umbrella name established in state law for all four program components, and which was marketed successfully during the first five years of the program's operation.

Eligibility Determination Process

Use a single entity to determine a child's financial eligibility for all of the Florida KidCare program components. (18 yes, 0 no, 0 abstentions)

The Department of Children and Families performs Medicaid eligibility determinations and uses the FLORIDA computer system. The Florida Healthy Kids Corporation contracts with a third-party administrator, which uses a different system for Title XXI eligibility determinations (the CHAS system).

The Healthy Kids Corporation's third-party administrator and the Department of Children and Families devised an inexpensive way for the FLORIDA computer system to communicate with and send eligibility information electronically to the Healthy Kids third-party administrator's computer system, but the interface does not yet work both ways completely.

Use of a single entity eligibility determination would reduce processing time and program complexity, and further streamline the Florida KidCare program, which are ongoing program goals.

To assist in addressing this and other administrative issues, the Florida Healthy Kids Corporation contracted with Health Management Associates and reconstituted its Eligibility Improvement Subcommittee, which includes members from each of the Florida KidCare partner agencies.

During deliberations, the council members observed that this recommendation is not needed if the broader council recommendation to create a single administration for all aspects of the Florida KidCare program is adopted. However, if the broader consolidation recommendation is not adopted, then using a single entity to determine financial eligibility for Florida KidCare is needed.

Policymaking, Rulemaking and Oversight Activities

The Legislature should give clear and broad rule-making authority to the Agency for Health Care Administration for Florida KidCare, and where appropriate, statutory language should be revised to conform to the Agency's rule-making authority. The Agency must develop these rules in conjunction with the Florida KidCare partners. (18 yes, 0 no, 0 abstentions)

Florida KidCare program responsibilities are divided between three state agencies (AHCA, DCF and DOH) and the Florida Healthy Kids Corporation. Legislation passed in 2004 assigns formal responsibility for Title XXI eligibility determination to the Florida Healthy Kids Corporation, which is a non-profit organization established in Section 624.91, F.S. The Department of Children and Families is responsible for Medicaid eligibility determination and it has administrative rules in place to govern how these responsibilities are discharged.

Section 409.818, F.S., specifies the duties of the various partner agencies. The statute assigns certain Title XXI functions to the Department of Children and Families, but DCF has never had direct responsibility for the Title XXI component, and the Agency for Health Care Administration, as the contract manager for the Florida Healthy Kids Corporation contract, monitors and pays for services through the contract provisions.

The program has implemented significant policies and procedures over time without benefit of the public input that is provided through the administrative rule process in Chapter 120, F.S. Moreover, it can be challenging for the public to obtain written explanations of the program's policies and procedures, particularly as they relate to the Title XXI-funded component for eligibility determination, denial of coverage or benefits, reinstatements, premium payments, and other processes that determine if a child will receive subsidized Florida KidCare coverage.

The council recognizes that the Florida KidCare partner agencies have been involved in a constant cycle of implementing, revising, and reconfiguring program policies in response to a variety of administrative and legislative changes. To ensure the public has the opportunity to comment and understand the policies, the council recommends that the Agency for Health Care Administration be assigned broad rule-making authority for the Florida KidCare program, with input from the Florida KidCare partner agencies.

Ensure rigorous independent evaluation of the effects of Medicaid reform. (18 yes, 0 no, 0 abstentions)

Florida is one of several States testing ways to modify its Medicaid program. The Agency for Health Care Administration's (AHCA) web site states: "For the first time, we will offer true flexibility in the program so health plans can better target the needs of the program's participants. We believe this innovative approach will better match health care services with the needs of the citizens we serve...."

Throughout 2005 and 2006, AHCA staff conducted outreach meetings with health plans, health care providers, consumers, and advocates to discuss and obtain input in Broward and Duval Counties, the first two pilot areas for reform. Subsequent to legislative authorization in 2005, AHCA applied for and received a Section 1115 Research and Demonstration Waiver to implement Medicaid reform. In its first quarterly report to the federal government, AHCA explained the purpose of Medicaid reform as follows:

"Through mandatory participation for specified populations in managed care plans that offer customized benefit packages and the

emphasis on individual involvement in selecting private health plan options, the State expects to gain valuable information about the effects of infusing market-based approaches with a public entitlement program.

Key components of reform include the following:

- *Comprehensive Choice Counseling;*
- *Customized Benefit Packages;*
- *Enhanced Benefits for participating in healthy behaviors;*
- *Low-Income Pool;*
- *Risk Adjusted Premiums based on enrollee health status; and*
- *Catastrophic Component of the premium (i.e., state reinsurance to encourage development of PSNs [provider service networks] and HMOs [health maintenance organizations] in rural and underserved areas of the State)."* (Florida Medicaid Reform, Quarterly Progress Report, July 1, 2006 – September 30, 2006, 1115 Research and Demonstration Waiver, December 2006)

Enrollment in the two pilot counties began in September 2006. As of January 2007, nine health maintenance organizations (HMOs) and five provider service networks (PSNs), including the Children's Medical Services Network, have 77,594 beneficiaries enrolled in their reform plans in Broward County. In Duval County, three HMOs and two PSNs have 51,479 Medicaid beneficiaries enrolled in their reform plans. The Children's Medical Services Network application to become a PSN for children with special health care needs in Duval County is still pending as of January 2007. (Medicaid presentation to Senate Health and Human Services Appropriations Committee, January 11, 2007)

AHCA has six evaluation objectives for its Medicaid reform demonstration waiver:

1. To ensure that there is an increase in the number of plans from which an individual may choose; an increase in the different types of plans; and increased patient satisfaction.
2. To ensure that there is access to services not previously covered and improved access to specialists.
3. To improve enrollee outcomes as demonstrated by: a) improvement in the overall health status of enrollees for select health indicators; b) reduction in ambulatory sensitive hospitalizations; and c) decreased utilization of emergency room care.
4. To determine the basis of an individual's selection to opt out and whether the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g. family health coverage).
5. To ensure that patient satisfaction increases.
6. To evaluate the impact of the low-income pool on increased access for uninsured individuals.

AHCA contracted for the required evaluation with the University of Florida. In addition to the contract with the University of Florida, a subcontract was developed with the Urban Institute (with funding from the Kaiser Family Foundation) to study the early impact of transition for Medicaid Reform enrollees. AHCA reports the following in its first quarterly report to the federal government:

1. Deliverable 1 (Detailed Workplan). This was a step-by-step map of the process and tasks to be undertaken by UF staff to complete the evaluation over year one, with estimates included for subsequent years.
2. Deliverable 2 (Summary Report on the Medicaid Reform Section 1115 Waiver Process). This report explains the Medicaid Section 1115 Waiver Process, and how it fits together with Medicaid Reform in Florida.
3. Deliverable 3 (Medicaid Reform Health Plans and Networks) describes managed care organizations and other Reform

Health Plans from the two Reform counties, Broward and Duval, in detail.

The University of Florida is conducting baseline Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys in Broward and Duval Counties. (Florida Medicaid Reform, Quarterly Progress Report, July 1, 2006 – September 30, 2006, 1115 Research and Demonstration Waiver, December 2006)

Ensuring that the evaluation captures critical information about children with special health care needs will be important to gauging the effectiveness of various service delivery systems for these children under Medicaid reform.

The National CAHPS Benchmarking Database cites four reasons to be concerned about children with special health care needs and to pay particular attention to their quality of care:

- *"These children have more complex health care needs than do children without special needs.*
- *The majority of public and private health care dollars spent on children goes to caring for this population.*
- *Federal mandates require Medicaid and SCHIP programs to identify children with special health care needs, monitor their access to certain services, and collect specific performance measures for them.*
- *There is a growing body of evidence that children with special needs often experience inadequate care."* (Quality of Care for Children with Special Health Care Needs: Medicaid Findings from the CAHPS Child Survey, Carla Zema, Ph.D., February 2004)

According to the CAHPS web site, to better address the needs of children with chronic conditions, the CAHPS Consortium decided in 2002 to integrate a new set of items into the CAHPS health plan questionnaires for children. The expanded Child Survey allows sponsors to:

- Identify children who have chronic conditions;
- Assess their experience with the health care system; and
- Compare it to the experiences of similar children in other health plans and/or children without chronic conditions in the same plan.

The CAHPS Child Survey includes 31 supplemental questions focusing on topics with special relevance to children with chronic conditions. Topics include:

- Access to prescription medicines;
- Access to specialized services;
- Access to family-centered care, including:
  - Having a personal doctor or nurse who knows the child.
  - Shared decision-making.
  - Getting needed information.
- Coordination of care and services. (*http://www.ahrq.gov/chtoolbx/measure2.htm*)

Because families of Medicaid children with special health care needs may choose the Children's Medical Services Network, other provider service networks or health maintenance organizations for their children, it is important for the evaluators to collect baseline information on these children and to incorporate the Child Survey with the Children with Chronic Conditions survey questions into their overall evaluation of the Medicaid reform pilot project.

Federal Recommendations

Reauthorize and increase SCHIP funding commensurate with each state's current growth projections. (25 yes, 0 no, 0 abstentions)
Provide sufficient federal funding and remove enrollment impediments from Title XXI of the Social Security Act, such as restrictions on public employees' children and immigrant children who would otherwise qualify for subsidies. (25 yes, 0 no, 0 abstentions)
Continue the current process of the redistribution formula to ensure all eligible states receive redistribution funds. (25 yes, 0 no, 0 abstentions)
Recognize and support efforts on the federal level to fund outreach and enrollment efforts in the States. (25 yes, 0 no, 0 abstentions)
Allow the Title XIX Vaccines for Children program to be used for the State Children's Health Insurance Program. (25 yes, 0 no, 0 abstentions)
Support initiatives to allow families who are ineligible due to income to buy into the Medicaid program. (23 yes, 0 no, 2 abstentions)
Repeal the Medicaid citizenship and identify documentation requirements. (23 yes, 0 no, 2 abstentions)

SCHIP Reauthorization. The federal SCHIP law is up for reauthorization in FFY 2007. Although the program is politically popular and has enjoyed bi-partisan support, many States, including Florida, enacted measures to reduce program costs in response to concerns that federal funds would be expended too soon (the "Chip Dip") and that upon reauthorization, the federal investment might be scaled back, leaving States with large caseloads and more state-funded costs. States' actions to rein in costs included instituting enrollment barriers through increased documentation, eliminating outreach, freezing enrollment, reducing or restricting eligibility, freezing or reducing provider payments, reducing benefits, and instituting higher cost-sharing requirements for enrollees.

Advocates and others are now concerned that States' prior cost-cutting actions may be interpreted as a lack of commitment to expanding coverage to more uninsured children. As a result, States with more aggressive programs will receive more federal funding while those that held down costs will receive less federal money, even if the unmet need is greater.

Several States either reversed earlier cost cutting measures or further expanded their programs. The Kaiser Commission on Medicaid and the Uninsured reports that from July 2005 to July 2006, 17 States expanded access to Medicaid and SCHIP by increasing eligibility (14 states), simplifying enrollment procedures (5 states), and reducing premiums for children's coverage (2 states).

The U.S. Census estimates that approximately 494,000 Florida children with family incomes at or below 200 percent of the federal poverty level were uninsured in 2005. These children may be eligible for Florida KidCare, and additional federal funding will be needed to ensure the State has sufficient resources for covering more children. To grow or even maintain its share of federal funding, Florida will need to act quickly by implementing

measures to simplify the program and grow the enrollment.

The council recommends that the federal government not only reauthorize the SCHIP program, but also increase its funding commitment so that states may continue to reach out to and cover eligible uninsured children. In addition, estimates of child uninsurance should be taken into account when the federal funding formula is re-enacted to ensure that federal funds are available to those areas with the highest need.

Legal Immigrant and Public Employees' Children. Federal Medicaid and SCHIP laws preclude subsidized coverage for certain pregnant women and children who are in the U.S. legally. A large number of children are in the country legally, but must wait five years before they can qualify for SCHIP benefits.

Due to federal immigration policies, Florida is home to one of the largest immigrant populations in the country. Because immigration policy is a federal issue, Florida is one of many States that have advocated for access to federal SCHIP funds to provide health services to children in the U.S. legally.

The Florida Healthy Kids program currently covers some children with state and local funds, but this is only a small amount of the total need. Legislation enacted in 2004 precludes enrollment of new children in state-subsidized Healthy Kids coverage. This provision, coupled with the federal exclusion of Title XXI funding for legal immigrant children, will exacerbate health disparities among children who already experience poorer health outcomes and access to care than other Florida children. Uncompensated care for these children also will increase as their parents end up seeking health care services in emergency rooms for conditions that could be prevented or treated in a less expensive primary care setting.

To prevent States from shifting costs for dependent coverage of public employees to the federal government, the federal Title XXI law prohibits States from extending subsidized coverage to these children, even if they would otherwise qualify for the program.

To promote affordable coverage for children and ensure that the program is viewed as treating families fairly, the council recommends removing from the federal law restrictions on federal funding for legal immigrant children and public employees' children who would otherwise meet Title XXI eligibility requirements.

Redistribution Formula. Under current federal law, federal Title XXI funds that a State has not spent in three years are available for redistribution to other States that have used all of their funds.

> In late 2006, Congress enacted legislation to transfer unspent federal Title XXI funds from States that did not use all of their allocations to States that were facing shortfalls. As a result, Florida will lose an estimated $20 million to support States that were more aggressive in covering their uninsured populations, even though almost half a million potentially eligible Florida children are uninsured.

From FFY 2001-FFY 2003, almost $120 million of Florida's SCHIP federal funds allocated during the first three years of the program reverted to the federal government for redistribution to other States.

As a result of fully spending its FFY 2001 and FFY 2002 SCHIP annual allotments, Florida has received almost $171 million in Title XXI redistribution funds. During 2004, the federal government raised the possibility of changing the redistribution formula to target unspent funds only to States that would have had inadequate funding in FFY 2005 to maintain their programs. Although not adopted, if this proposal had been implemented, only six States would have been eligible for a share of the $643 million in unspent SCHIP federal funds. Florida would not have been one of these States.

In late 2006, Congress enacted legislation to transfer unspent federal Title XXI funds from States that did not use all of their allocations to States that were facing shortfalls. As a result, Florida will lose an estimated $20 million to support States that were more aggressive in covering their uninsured populations, even though almost half a million potentially eligible Florida children are uninsured.

The council recommends fully funding the Florida KidCare program, including growth and annualization needs, which would result in maximizing the use of the State's federal Title XXI allotment. To support this, the council recommends that the federal government continue the current process of the redistribution formula to ensure that all eligible States receive an equitable share of the unspent funds.

Outreach. Migration is the largest source of population growth in Florida and potential new customers for Florida KidCare need to be aware that there is an affordable health insurance product available to families with uninsured children. While the 2006 Florida Legislature authorized $1 million in non-recurring state general revenue funding for a community-based marketing and outreach grant program, there is still a need for broader efforts. Marketing and outreach not only helps people learn about the Florida KidCare program, community organizations also assist families in gathering the necessary documents, completing the application, and guiding them through the application and renewal process. These activities are essential to growing and sustaining program enrollment. The council supports initiatives that would provide additional federal funds to help support the resumption of a more robust outreach program in Florida. The members also endorsed separating funding for outreach from each State's overall 10 percent limit on administrative costs.

Vaccines for Children. This program, administered by the national Centers for Disease Control, provides free vaccines to health care providers who serve eligible children. Under federal regulations, children from birth through age 18 are eligible to receive free vaccines if they meet the following requirements:

- Are enrolled in Medicaid, or
- Have no health insurance, or
- Are American Indians or Native Alaskans, or
- Are covered by a health insurance plan that does not provide for immunizations.

Children enrolled in Title XXI-financed coverage are not eligible to receive vaccines under the Vaccines for Children program. To ensure that all children have timely access to immunizations and reduce barriers for providers, the council recommends allowing providers to use the Vaccines for Children program for Title XXI-funded children, in addition to those currently eligible for the Medicaid program.

Medicaid Buy-In. As part of the Deficit Reduction Act of 2005, Congress authorized the Family Opportunity Act, which permits States to extend a Medicaid buy-in option to families with incomes up to 300 percent of the federal poverty level whose children would meet Supplemental Security Income (SSI) requirements, except for income. This provision gives States the flexibility to offer a Medicaid product to moderate income families, and the council recommends more options to give other families with uninsured members a similar opportunity, particularly as employer-sponsored dependent coverage becomes less available and more costly for workers and their families.

Medicaid Documentation Requirements. The Deficit Reduction Act of 2005 contained new requirements for the Medicaid program to verify U.S. citizenship and identity. With few exceptions, these requirements apply to all Medicaid applicants and participating beneficiaries — including children. The federal Centers for Medicare and Medicaid Services, which administers Medicaid and SCHIP, has stated that: "All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted." (State Medicaid Director letter, SMDL 06-012, June 9, 2006).

The Department of Children and Families (DCF), which is responsible for determining Medicaid eligibility in Florida, issued a list of

documents that may be used to comply with the federal requirements (**Table 7**). Applicants and beneficiaries are given 10 days to return the documentation. If the person indicates difficulty or inability to obtain the documents, the department will assist them. While the department uses computer matches with the Department of Health's Office of Vital Statistics to verify citizenship for people born in Florida, providing proof of citizenship for those not born in the state coupled with documentation of each individual's identity is problematic.

Table 7: Medicaid Citizenship and Identity Documentation

These Documents Verify BOTH Citizenship and Identity:	These Documents Verify Citizenship:	These Documents Verify Identity:
• U.S. passport • Certificate of Naturalization • Certificate of U.S. Citizenship	• U.S. birth certificate originally issued prior to age 5 • Vital Statistics Records • U.S. Citizen ID card • Northern Mariana ID card • American Indian card • A final adoption decree • A document showing civil service employment before June 1, 1976; • Official military record of service showing U.S. place of birth; or • Attestations: • Two written, signed statements (1 non-relative) from individuals who have personal knowledge of the birth and explaining why the documentation does not exist or cannot be obtained (if they are aware of the reasons) • A separate attestation from the applicant/beneficiary, guardian or representative, explaining why the documentation is not available	• State driver's license with photo • State issued ID card with photo • Work or school ID card with photo (no photo required for children under age 16) • Federal, State, or local government ID card with photo; • U.S. military ID card or draft record • Native American tribal document • If no other identifying documentation exists for a child under age 16, an affidavit signed by the parent or guardian stating the date and place of the child's birth. Cannot use an attestation for both citizenship and identity, only for citizenship or identity.

The department has worked to minimize the potential impacts of the new federal requirements, but early evidence suggests the documentation requirements are having an adverse impact on both Medicaid enrollment *and* Title XXI SCHIP enrollment. Children may not be considered for Title XXI-funded coverage until their Medicaid eligibility has been determined. If families do not provide required documents or identity attestation forms for their children, then the case is closed for non-compliance with Medicaid, and the children do not receive any coverage.

Research from a 50-State survey by the Kaiser Commission on Medicaid and the Uninsured shows that the new documentation requirements also increase States' administrative costs. (**Figure 8**)

The council recommends that the federal Medicaid citizenship and identity requirements be repealed to remove administrative barriers to coverage.

Figure 8: States' Reporting on Impact of Deficit Reduction Act Citizenship Documentation Requirements

Source: Kaiser Commission on Medicaid and the Uninsured survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2006

Glossary of Abbreviations/Terms

AHCA	The Agency for Health Care Administration administers the MediKids program for children ages 1 through 4. The Agency also works with the federal government to make sure the program follows all federal laws and rules.
BNet	Behavioral Health Network for children with serious emotional disturbances, ages 5 through 18, administered by the Department of Children and Families
CMS	▪ Children's Medical Services – a program within the Department of Health that provides a coordinated, managed system of health care for children with special health care needs who meet clinical eligibility requirements ▪ Federal Centers for Medicare and Medicaid Services, established within the Department of Health and Human Services, it is the federal agency that administers various health care programs, including Medicaid and the State Children's Health Insurance Program
CSHCN	Children with special health care needs
DCF	The Department of Children and Families determines eligibility for the Medicaid program
DOH	The Department of Health administers the Children's Medical Services (CMS) Network for children with special health care needs from birth through age 18. The Department also staffs the KidCare Coordinating Council (KCC), which is established in state law to provide recommendations to the Governor and Legislature on the operation and implementation of the Florida KidCare children's health insurance program
FHKC	The Florida Healthy Kids Corporation administers the Florida Healthy Kids program for children ages 5 through 18. The corporation also determines eligibility for the non-Medicaid parts of the program, collects monthly premiums, and manages the customer service call center
FIFI	Florida Institute for Family Involvement, organization of parent-to-parent support, assistance with resource identification and problem-solving for parents of children with special health care needs
Florida KidCare	The name of Florida's State Children's Health Insurance Program (SCHIP). Authorized in ss. 409.801-409.8122, F.S., Florida KidCare consists of four components: MediKids, Healthy Kids, the Children's Medical Services Network, and Medicaid for Children
FPL	Federal Poverty Level; established by the federal government annually, used by federal, state and local governments to establish financial eligibility for publicly-financed programs and services. New FPL is published April 1 each year
FY **FFY**	State Fiscal Year: Starts July 1 and ends June 30 of the following year Federal Fiscal Year: Starts October 1 and ends September 30 of the following year
HMO	Health maintenance organization. Licensed under Chapter 641, F.S.
Medicaid or Title XIX	Medicaid is a federal/state entitlement program that provides health coverage to low-income individuals who meet income and other categorical requirements. Established and authorized by Title XIX of the Social Security Act
SCHIP or Title XXI	State Children's Health Insurance Program, a federal/state non-entitlement program for uninsured children with incomes above Medicaid levels. Established and authorized by Title XXI of the Social Security Act
Social Services Estimating Conference (SSEC)	Consists of professional staff of the Governor's Office, the Legislature and partner agencies who meet to agree upon caseload and expenditure forecasts needed to support the planning and budgeting process

KidCare Appropriations March SSEC updated with April 2006 CMS, Medikids and FHK TitleXXI forecasts
CONFERENCE AGREEMENT 2006-2007
Adjusted on 6-29-06 for Tobacco/General Revenue Fund Shift

KidCare Appropriations

Funding Year	Avg Caseload	Member Months	PMPM Cost	Total Cost	Tiered Family Paymt $15/$20	Net Cost	*Federal Share 71.1525%	State Share	Local Share	FHK Cash	State Share GR	State Share Tobacco
FLORIDA HEALTHY KIDS CORP												
Services												
FHK - Full Pay (Non-Title XXI)	23,874	286,490	$100.98	$28,929,760	$28,929,760	$0	$0	$0	$0	$0	$0	$0
FHK - Subsidized (Non-Title XXI)	1,926	23,111	$105.20	$2,431,277	$ 202,683	$2,228,594	$0	$2,228,594	$328,594	$1,900,000	$0	$0
FHK - Title XXI	195,867	2,350,401	$98.97	$232,619,236	$ 24,209,135	$208,410,101	$148,288,997	$60,121,104	$0		$0	$60,121,104
Sub-Total	221,667	2,660,002		$263,980,273	$53,341,578	$210,638,695	$148,288,997	$62,349,698	$328,594	$1,900,000	$0	$60,121,104
Administration												
FHK - Full Pay (Non-Title XXI)	23,874	286,490	$5.82	$1,667,372	$1,667,372	$0	$0	$0	$0	$0	$0	$0
FHK - Subsidized (Non-Title XXI)	1,926	23,111	$5.82	$134,506		$134,506	$0	$134,506	$134,506	$0	$0	$0
FHK - Title XXI	195,867	2,350,401	$5.82	$13,679,337		$13,679,337	$9,733,190	$3,946,147	$0		$0	$3,946,147
Sub-Total	221,667	2,660,002		$15,481,215	$1,667,372	$13,813,843	$9,733,190	$4,080,653	$134,506	$0	$0	$3,946,147
FLORIDA HEALTHY KIDS CORP												
FHK - Full Pay (Non-Title XXI)	23,874	286,490	$106.80	$30,597,132	$30,597,132	$0	$0	$0	$0	$0	$0	$0
FHK - Subsidized (Non-Title XXI)	1,926	23,111	$111.02	$2,565,783	$202,683	$2,363,100	$0	$2,363,100	$463,100	$1,900,000	$0	$0
FHK - Title XXI	195,867	2,350,401	$104.79	$246,298,573	$24,209,135	$222,089,438	$158,022,187	$64,067,251	$0	$0	$0	$64,067,251
Total FY 2006-07 FHK Estimate	221,667	2,660,002		$279,461,488	$55,008,950	$224,452,538	$158,022,187	$66,430,351	$463,100	$1,900,000	$0	$64,067,251
FY 2005-06 Appropriation				$410,027,851	$0	$354,035,087	$245,197,167	$108,959,375	$7,000,000	$950,000	$32,589,724	$68,419,651
Budget Required				($130,566,363)	$55,008,950	($129,582,549)	($87,174,980)	($42,529,024)	($6,536,900)	$950,000	($32,589,724)	($4,352,400)
FHK Dental ($750 Annual Cap)												
FHK - Full Pay (Non-Title XXI)	23,874	286,490	$9.89	$2,833,386	$2,833,386	$0	$0	$0	$0	$0	$0	$0
FHK - Subsidized (Non-Title XXI)	1,926	23,111	$11.59	$267,856		$267,856	$0	$267,856	$267,856	$0	$0	$0
FHK - Title XXI	195,867	2,350,401	$11.59	$27,241,153		$27,241,153	$19,382,761	$7,858,392	$0		$7,858,392	$0
Total FY 2006-07 DENTAL Estimate	221,667	2,660,002		$30,342,395	$2,833,386	$27,509,009	$19,382,761	$8,126,248	$267,856	$0	$7,858,392	$0
FY 2005-06 Appropriation				$49,273,023	$0	$49,273,023	$33,052,773	$16,254,541		$950,000	$15,304,541	$0
Budget Required				($18,930,628)	$2,833,386	($21,764,014)	($13,670,012)	($8,128,293)	$267,856	($950,000)	($7,446,149)	$0
FLORIDA HEALTHY KIDS CORP												
FHK - Full Pay (Non-Title XXI)	23,874	286,490	$116.69	$33,430,518	$33,430,518	$0	$0	$0	$0	$0	$0	$0
FHK - Subsidized (Non-Title XXI)	1,926	23,111	$122.61	$2,833,639	$202,683	$2,630,956	$0	$2,630,956	$730,956	$1,900,000	$0	$0
FHK - Title XXI	195,867	2,350,401	$116.38	$273,539,726	$24,209,135	$249,330,591	$177,404,948	$71,925,643	$0	$0	$7,858,392	$64,067,251
Total FY 2006-07 FHK Estimate	221,667	2,660,002		$309,803,883	$57,842,336	$251,961,547	$177,404,948	$74,556,599	$730,956	$1,900,000	$7,858,392	$64,067,251
FY 2005-06 Appropriation		0		$459,300,874	$0	$403,308,110	$278,249,940	$125,213,916	$7,000,000	$1,900,000	$47,894,265	$68,419,651
Budget Required				($149,496,991)	$57,842,336	($151,346,563)	($100,844,992)	($50,657,317)	($6,269,044)	$0	($40,035,873)	($4,352,400)
MEDIKIDS					GD TF							
Total FY 2006-07 Medikids Estimate	21,000	252,000	$106.41	$26,815,320	$ 2,010,960	$24,804,360	$17,648,922	$7,155,438	$0	$0	$0	$7,155,438
FY 2005-06 Appropriation		0	$92.10	$58,427,527	$5,405,472	$53,022,055	$37,767,498	$15,254,557			$7,083,923	$8,170,634
Budget Required				($31,612,207)	($3,394,512)	($28,217,695)	($20,118,576)	($8,099,119)	$0	$0	($7,083,923)	($1,015,196)
CHILDREN'S MEDICAL SERVICES					GD TF							
Total FY 2006-07 CMSN Estimate	11,292	135,504	$564.88	$76,543,500	$ 1,016,280	$75,527,220	$53,739,505	$21,787,715	$0	$0	$6,168,541	$15,619,174
FY 2005-06 Appropriation		0	$518.24	$63,929,679	$878,485	$63,051,194	$44,911,366	$18,139,828			$8,993,070	$9,146,758
Budget Required				$12,613,821	$137,795	$12,476,026	$8,828,139	$3,647,887	$0	$0	($2,824,529)	$6,472,416
BEHAVIORAL HEALTH SERVICES												
Total FY 2006-07 BHSN Estimate	472	5,664	$1,000.00	$5,664,000	$0	$5,664,000	$4,030,078	$1,633,922	$0	$0	$1,633,922	$0
FY 2005-06 Appropriation		0	$1,000.00	$4,657,500	$0	$4,657,500	$3,317,537	$1,339,963			$235,143	$1,104,820
Budget Required				$1,006,500	$0	$1,006,500	$712,541	$293,959	$0	$0	$1,398,779	($1,104,820)
EXPENSES												
Total FY 2006-7 EXPENSE Estimate	32,292	387,504	$9.99	$3,871,165	$0	$3,871,165	$2,754,431	$1,116,734			$412,186	$704,548
FY 2005-06 Appropriation				$9,720,598	$0	$9,720,598	$6,924,463	$2,796,135			$2,091,587	$704,548
Budget Required				($5,849,433)	$0	($5,849,433)	($4,170,032)	($1,679,401)	$0	$0	($1,679,401)	$0
TOTAL ALL					GD TF							
Total FY 2006-07 Estimate	253,959			$422,697,868	$ 3,027,240	$361,828,292	$255,577,884	$106,250,408	$730,956	$1,900,000	$16,073,041	$87,546,411
FY 2005-06 Appropriation				$596,036,178	$6,283,957	$533,759,457	$371,170,804	$162,744,399	$7,000,000	$1,900,000	$66,297,988	$87,546,411
Budget Required				($173,338,310)	($3,256,717)	($171,931,165)	($115,592,920)	($56,493,991)	($6,269,044)	$0	($50,224,947)	$0

GR Cut	($50,224,947)
MCTF Cut	($115,592,920)
GDTF Cut	($3,256,717)
Total Cut	($169,074,584)

Note:
PMPM cost from March 2006 KidCare estimating conference.
Shaded areas are not budgeted in state accounts.
*Matching rate is a blend of the FMAP for July, August and Septemeber (71.22%) and the FMAP for October - June (71.13%)

Appendix