

Contract No.: HHS-100-01-0002
MPR Reference No.: 8782-071

MATHEMATICA
Policy Research, Inc.

**Congressionally Mandated
Evaluation Of The State
Children's Health
Insurance Program**

*Site Visit Report: The State of
Florida's KidCare Program*

May 2003

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I. PROGRAM OVERVIEW

Florida's child health program consists of four components that, together with the state's Title XIX Medicaid program for children, comprise an umbrella program called *KidCare*. The Title XXI portion of *KidCare* combines a small Medicaid expansion with three separate child health insurance components, the largest of which, *Healthy Kids*, predated federal SCHIP legislation and was one of three state programs in the nation given "grandfathered" status under Title XXI (the other two states are New York and Pennsylvania). Florida's initial plan for its State Children's Health Insurance Program (SCHIP), submitted in early December 1997 and implemented in April 1998, expanded and modified certain aspects of the existing *Healthy Kids* program to comply with federal requirements, and added a Medicaid expansion to accelerate the federally mandated phase-in of Medicaid coverage for adolescents (Table I.1). A subsequent amendment added two more SCHIP components—one for children under age 5 and another for children with special health care needs. The amendment also formally established *KidCare* as the umbrella program that would bring together SCHIP and Medicaid for children. Key features of the Title XXI *KidCare* components are summarized below and also in Table I.2 and Figure I.1:

- ***Medicaid expansion***, for adolescents and (as of July of 2000) infants under age 1. The expansion included adolescents under age 19 in families with incomes between 28 and 100 percent of the federal poverty level (FPL), and infants in families with incomes from 186 to 200 percent of the FPL. Teenage children aged out of the Medicaid expansion as of October 1, 2002.
- ***MediKids***, a separate child health program, covering children ages 1 to 5 in families with incomes between 134 and 200 percent of FPL.
- ***Healthy Kids***, a separate child health program, for children ages 5 to 19 in families with incomes under 200 percent of FPL (134 to 200 percent FPL for 5 year olds, and 101 to 200 percent FPL for children ages 6 to 19).

TABLE I.1
SCHIP STATE PLAN AND AMENDMENTS

Document	Submitted	Dates		Description
		Approved	Effective	
Original Submission	12/4/97	3/5/98	4/1/98	Submitted a Title XXI plan to (1) expand Medicaid coverage to children ages 15 through 19 with family incomes from 28-100 percent of the FPL; and (2) modify the existing <i>Florida Healthy Kids</i> program to meet the requirements of Title XXI and expand it to additional counties throughout the state.
Amendment 1	7/17/98	9/8/98	7/1/98	(1) Expanded eligibility for the <i>Healthy Kids</i> program from 186 to 200 percent of the FPL; (2) created the <i>MediKids</i> program for children ages 0 to 5 with family incomes below 200 percent of the FPL; and (3) modified the Children's Medical Services (<i>CMS</i>) Network to include children ages 0 to 19 with family incomes below 200 percent of the FPL.
Amendment 2	12/2/98	Denied		Amendment to provide premium assistance to cover children through employer-sponsored coverage.
Amendment 3	12/27/99	3/31/00	10/1/99	Implemented a pilot program under <i>Healthy Kids</i> with a minimum dental benefit package in two counties (Palm Beach and Dade). The 2000 Florida State Legislature approved the addition of a comprehensive dental benefit to the <i>Healthy Kids</i> benefit package. Counties are required to provide a minimum level of local matching funds to participate in the <i>Healthy Kids</i> dental component.
Amendment 4	8/14/00	11/8/00	7/1/00	Expanded Medicaid coverage to children under age 1 with family incomes from 186-200 percent of FPL (children previously covered under <i>MediKids</i> and the Title XXI <i>CMS</i> Network).
Amendment 5	3/12/01	6/7/01	2/1/01	Extended dental coverage to enrollees in the <i>Healthy Kids</i> program who live in counties contributing at least \$4,000 annually in local match funds.
Amendment 6	7/2/02		7/1/02	This is a federally required amendment to indicate the state's compliance with the final SCHIP regulations. This amendment also initiates improvements to the <i>KidCare</i> eligibility process.
Amendment 7	7/29/02	10/22/02	7/1/02	Implemented a school-based health services initiative which includes services such as direct health services, medical supervision and coordination for pregnant and parenting students, clinical intervention services, and health education.

TABLE I.1 (continued)

SOURCE: State of Florida. *Florida KidCare Program: Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Health Care Financing Administration*. July 2000. Centers for Medicare & Medicaid Services (CMS), *Florida Title XXI Program Fact Sheet*. Available at [<http://www.cms.gov/schip/chpfsfl.pdf>]. Accessed: March 6, 2003.

SCHIP = State Children's Health Insurance Program

FPL = federal poverty level

TABLE I.2

SCHIP AND MEDICAID INCOME ELIGIBILITY STANDARDS
AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL

	Age			
	Up to 1	1 to 5	5	6 to 19
Medicaid standards in effect on March 31, 1997	185%	133%	133%	28%
SCHIP Program (Title XXI)				
Medicaid Expansion	186-200%			29-100%
<i>MediKids</i>		134-200%		
<i>Florida Healthy Kids</i>			134-200%	101-200%
Children's Medical Services Network	186-200%	134-200%	134-200%	101-200%

SOURCE: State of Florida. *Florida KidCare Program: Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Health Care Financing Administration*. July 2000. Medicaid standards based on : "The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999." Available online at [<http://www.cms.gov/schip/enroll99.pdf>]. Accessed: March 5, 2003.

SCHIP = State Children's Health Insurance Program

FPL = federal poverty level

FIGURE I.1

SCHIP AND MEDICAID INCOME ELIGIBILITY STANDARDS
AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL

		Age of Child			
		Up to 1	1 to 5	5	6 to 19
Percent of FPL	200	Medicaid Expansion/ <i>CMS</i>	<i>MediKids/CMS</i>	<i>Healthy Kids/ CMS</i>	<i>Healthy Kids/CMS</i>
	185				
	133	Medicaid Title XIX ^a	Medicaid Title XIX ^a	Medicaid Title XIX ^a	Medicaid Expansion
100	Medicaid Title XIX ^a				
28					Medicaid Title XIX ^a

SOURCE: See source Table I.2.

^aMedicaid standards in effect on March 31, 1997.

- ***Children’s Medical Services (CMS) Network***, a separate child health program, for children ages 1 to 19 with special health care needs (the income range for children ages 1 to 6 is 134 to 200 percent of FPL, and 101 to 200 percent of FPL for children ages 6 to 19). In addition there is a small (303 slots) subcomponent within *CMS*, the Behavioral Health Specialty Care Network (BHSCN), for Title XXI eligible children ages 5 to 19 with more serious mental health or substance abuse related needs.

Like the program structure, the administration of *KidCare* is complex. Administrative responsibilities for different *KidCare* components are shared among the following four entities:

- The **Agency for Health Care Administration (AHCA)** submitted the state’s SCHIP plan and plan amendments, is the fiscal agent for federal SCHIP funds, and is the lead agency for Medicaid and the SCHIP program. The agency also administers the Medicaid expansion component as well as the *MediKids* program, and provides oversight of the Florida Healthy Kids Corporation (see below).
- The **Florida Healthy Kids Corporation (FHKC)** administers the *Healthy Kids* program and, under contract with the Agency for Health Care Administration, is responsible for (1) receiving and processing mailed *KidCare* applications and premium payments; (2) conducting the initial screenings and referrals for Medicaid and *CMS* medical eligibility determinations; and (3) conducting eligibility determinations for *Healthy Kids*, *MediKids* and the *CMS Network* (non-medical eligibility).
- The **Department of Health (DOH)** has lead responsibility for *KidCare* outreach, administers the *CMS* component (including clinical eligibility determination), and partners with the Department of Children and Family Services, Mental Health and Substance Abuse Program Offices to jointly administer the Behavioral Health Specialty Care Network.
- The **Department of Children and Family Services (DCFS)** conducts Medicaid eligibility determinations (for Title XIX and the Title XXI expansion), and partners with the Department of Health to administer the Behavioral Health Specialty Care Network (BHSCN).

The *KidCare* legislation also created an interagency *KidCare* Coordinating Council to oversee *KidCare* and provide advice on program and policy issues. The coordinating council is chaired by the Department of Health and includes representatives from the partner entities listed above as well as advocacy groups, providers, health plans, and *KidCare* families.

In a case study (described below) conducted in November 2001, providers and advocates we met with voiced concerns about the lack of one lead agency to serve as the primary point of contact under *KidCare*. Without this lead agency, they noted, it is much harder to advocate for and implement program changes. The *KidCare* Coordinating Council provides a forum for addressing concerns that may cut across the different program components, but it plays an advisory role and does not have the authority to set policy. At the time of the site visit, the coordinating council was set to recommend that a single agency be chosen to lead *KidCare*.

In December 2002, 281,269 children were enrolled in SCHIP components of *KidCare*, (State of Florida 2002). The Institute for Child Health Policy's fourth evaluation report (Shenkman and Bono 2003) estimated that there were 753,915 children eligible for *Healthy Kids* and *MediKids* in 2002, and that approximately 80 percent of them were enrolled. By far the largest share of SCHIP enrollment in Florida, 85 percent, is in the *Healthy Kids* component. Title XIX Medicaid enrollment totaled 1,135,987 in this same month, up from 720,984 when the state began implementing SCHIP in April 1998 (State of Florida 2003).

This case study is based primarily on a site visit to Florida conducted November 26 to 30, 2001 as part of the Congressionally Mandated Evaluation of the State Children's Health Insurance Program. The visit included interviews with state agency staff, legislators, child health advocates, front-line eligibility workers, health care providers, and staff of organizations involved in outreach and application assistance. (See Appendix A for a list of informants.) To gather information about policy development and local implementation of *KidCare*, our time on site was divided between the state capitol (Tallahassee), a major urban center (Fort Lauderdale and Broward County), and a rural area (City of Okeechobee). The Urban Institute team who studied the Florida SCHIP program and conducted a site visit in November 1999, before this

project began, provided additional information about the program's development and early implementation experiences.

II. BACKGROUND AND HISTORY OF SCHIP POLICY

The design of Florida's SCHIP program was influenced considerably by two existing state programs: *Florida Healthy Kids*, a subsidized insurance program for school-age children ages 5 to 19, and Children's Medical Services (*CMS*), the state's Title V Children with Special Health Care Needs (*CSHCN*) program. Florida's *Healthy Kids* initiative was launched in 1990, initially as a Medicaid Section 1115 research and demonstration program, to test school-based alternatives for expanding coverage to uninsured children. The demonstration sought to test whether a small premium subsidy would encourage parents to enroll uninsured children in a health insurance program. The state also hoped to improve access by stimulating greater participation among physicians. At the time, Florida's Medicaid program paid physicians 85 to 90 percent of Medicare's physician fees but they still had great difficulty getting enough doctors to participate.

While awaiting approval by the Centers for Medicare & Medicaid Services (then, the Health Care Financing Administration) for the Medicaid research and demonstration program, the state secured other start-up funds to establish the infrastructure for *Healthy Kids*, which would operate as a public-private partnership led by the newly established Florida Healthy Kids Corporation (*FHKC*). Federal funding for the program began in 1990, and the demonstration got underway two years later in Volusia County. Roughly 8,000 children were covered under the program during its first three years. For families with incomes under 100 percent of the federal poverty level, premium costs were fully subsidized. Families with incomes of 100 to 200 percent FPL paid from \$2.50 to \$25 per child per month, and families above the 200 percent threshold paid the full premium amount.

While the 3-year demonstration continued in Volusia County, *Healthy Kids* was expanded to additional counties starting in 1993 using only state and local funds. Counties were phased in gradually and by the time federal SCHIP legislation passed *Healthy Kids* was operating in 24 out of 67 Florida counties. A county-based local financing requirement was included in the expansion so that the program could be sustained without federal funds. Initially the policy was that a county's percentage contribution would start at 5 percent and increase annually until reaching the maximum contribution level of 40 percent. With the onset of SCHIP and the availability of federal matching funds, local match policies became more controversial and the pros and cons of the local match were being debated vigorously at the time of the site visit.

Healthy Kids was designed to resemble a private insurance product. It has always included cost sharing in the form of premiums and copayments, and the benefit package is similar to that found in many private insurance plans. *Healthy Kids* also adopted a managed care delivery system, contracting with Health Maintenance Organizations (HMOs) and making HMO enrollment mandatory.

Florida's Title V CSHCN program, administered by the Department of Health, had been developing and strengthening its provider network for decades prior to SCHIP. Through the years they had succeeded in building strong relationships with children's hospitals, specialists, and primary care physicians and in setting up regional *CMS* units throughout the state that provide care coordination and support for children and families. In 1996, the *CMS* network became an optional component for children with special health care needs under Florida's Medicaid managed care initiative. Title V funds also covered the full range of services for income-eligible children lacking other forms of insurance, and provided "wrap-around" coverage for services excluded by Medicaid and private insurance plans. Throughout this long history,

CMS established a good reputation as a well-managed program, paving the way for its adoption as a program component under SCHIP.

When it came time to design the SCHIP program in Florida, strong resistance to expanding the Medicaid entitlement, combined with support for the existing *Healthy Kids* and *CMS* infrastructures, gave rise to the multi-component structure of Florida's *KidCare* program. Major increases in the state's Medicaid spending since the late-1980's had motivated state lawmakers to control that state spending. At the same time, state leaders wanted something in place right away so the state could begin accessing federal funds for programs that would otherwise be financed solely with state and local funds. The state's phased approach allowed it to implement certain components right away while giving them more time to design the features of new program components.

Early in December 1997, Florida submitted Phase I of its SCHIP plan, to accelerate the phase-in of Medicaid coverage for adolescents (which was already on the state's agenda), and bring the existing *Healthy Kids* program (which covered children ages 6 to 19 under 185 percent FPL) into compliance with Title XXI requirements. Minor adjustments were made to the Florida *Healthy Kids* benefit package and cost sharing provisions, and the program was slated to become statewide. The Phase I plan was approved by the Centers for Medicare & Medicaid Services in early March and took effect on April 1, 1998 (Table I.1).

In July of 1998, the state submitted Phase II of its plan, establishing the *MediKids* component for children under age 5 in families with incomes under 200 percent of FPL, and adding the *CMS* network component for children with special health care needs (ages 0 to 19) in families with incomes under 200 percent of FPL. The amendment also increased the income threshold for *Healthy Kids* from 186 to 200 percent of FPL. These components were introduced following passage of state legislation authorizing additional coverage expansions and

establishing the new *KidCare* framework. The most significant debates leading up to this legislation were about strategies for expanding coverage to children under age 5. One option considered would have folded these children into *Healthy Kids*, to streamline the overall program structure, build on the positive image and operational successes of *Healthy Kids*, and eliminate age-related eligibility distinctions that could confuse families. Another option would have enrolled the younger children in Medicaid, which would also have streamlined the program, as well as given these children the comprehensive coverage available through Medicaid's Early and Periodic Screening, Diagnosis and Testing (EPSDT) provisions. Strong opinions on both sides of these debates led to consideration of a third option, which was adopted, to create a separate program that looks like Medicaid in most respects other than the entitlement. They named this program *MediKids*. Key informants involved in the debates cited various reasons why Medicaid and *Healthy Kids* expansions were rejected in favor of a separate program component for younger children:

- Strong political resistance to expanding the Medicaid entitlement
- Influential state leaders worried that further expansion of *Healthy Kids* to include younger children would detract from the primary educational mission of the schools
- The *Healthy Kids* benefit package and its cost sharing provisions were not considered adequate (benefits) or appropriate (cost sharing) for very young children

Under *MediKids*, children are covered by the Medicaid benefit package. There are no copayment requirements, but families are required to pay a small monthly premium.

The other strategy considered for children with special health care needs was to fold them into *Healthy Kids* or *MediKids* and have *CMS* provide wrap-around coverage for any excluded or limited services. This approach was ultimately rejected, though, because the wrap-around approach would be complicated to administer, and because the *CMS* program had an excellent

record of managing care effectively for this vulnerable population. Furthermore, the *Healthy Kids* program strongly favored maintaining the CMS role of serving children with special health care needs because *Healthy Kids* wanted to limit premium increases associated with serving this higher-need population. The final element of the Phase II plan was a small carve-out (303 slots) within the *CMS* component for children with mental health or substance abuse needs. State funding for that component was redirected from the state's mental health and substance abuse block grant programs.

Florida's *KidCare* legislation also created a non-subsidized buy-in component under *MediKids* and *Healthy Kids*, permitting families with incomes above 200 percent of FPL to purchase *Healthy Kids* or *MediKids* coverage at the full premium cost. However, *MediKids* has not implemented a buy-in to its benefits package due to the high premiums and administrative costs that would be required. The *Healthy Kids* buy-in component is financed solely with family contributions. To limit expenditures and adverse selection, the *KidCare* legislation limits enrollment in these buy-in components to no more than 10 percent of total *MediKids* or *Healthy Kids* enrollment. As discussed further in Chapter IX, the state also tried to implement an employer-sponsored premium assistance component under Title XXI, but this request was denied by the Centers for Medicare & Medicaid Services.

Other significant changes since the onset of SCHIP in Florida include the addition of a comprehensive dental benefit under *Healthy Kids*, and the shift of infants from *MediKids* and *CMS* into Medicaid. The dental benefit was introduced first in a two-county pilot program approved in March 2000. Remaining counties were phased in such that dental coverage was available statewide by mid-2002. For infants under age 1, the Medicaid income threshold was increased to 200 percent of FPL in July of 2000, effectively transferring infants in the 186 to 200 percent FPL range from *MediKids* and *CMS* to Medicaid.

The state has supported evaluations of its children's health insurance programs since the earliest days of *Healthy Kids*. The evaluation contractor, the Institute for Child Health Policy (ICHP), played a key role in shaping the initial *Healthy Kids* demonstration program and has conducted annual evaluations of that program since 1992. While continuing to conduct special studies of *Healthy Kids*, ICHP assumed the role of evaluating the larger *KidCare* program when it began in 1998. In addition to evaluating administrative and operational aspects of the program, ICHP conducts regular surveys of parents of enrolled and disenrolled children to evaluate a range of areas including access and quality of care. Findings are reported in annual evaluation reports that are available on the ICHP website.¹ In addition, ICHP conducts regular analyses of application and enrollment data, and compiles statistics that are also posted on the program's web page.

¹These annual evaluation reports (Shenkman et al. 2000, 2001, 2002; Shenkman and Bono 2003) are available at [<http://www.ichp.edu/FloridaKidCare/flaKC.htm>]

III. OUTREACH

A. INTRODUCTION

In creating the umbrella *KidCare* framework for Medicaid and SCHIP, Florida's legislators and agency leaders established the foundation for promoting all publicly funded health programs for children consistently. This unified approach was thought to be especially important because of the complex multi-component structure underlying *KidCare*. If successful, families would identify *KidCare* as "one" program, and the rules and processes unique to each program would be applied "behind the scenes" to reinforce the notion of a single program serving Florida's children. The new *KidCare* structure would also provide an opportunity to overcome some of the negative public/consumer perceptions that had come to be associated with the Medicaid program. Making this work, however, required fast action to unify the infrastructure to make it as seamless as possible for families. One of the more urgent tasks was to create a single application that would serve the four *KidCare* program components. To the amazement of many, the *KidCare* partners reached consensus on a new single-page application in time for *KidCare's* launch in Summer 1998. By all accounts, the group's success in meeting this ambitious milestone was a source of pride and gave the partners confidence in their ability to address subsequent implementation challenges.

As with other facets of the program, Florida took advantage of existing outreach and marketing strategies so it could implement *KidCare* quickly. In particular, the *Healthy Kids* program had a well-developed infrastructure for marketing to families with school-age children. *Healthy Kids* operated a telephone hotline to assist families during the application and enrollment process. The state decided to build on the *Healthy Kids* infrastructure in designing the outreach component for the larger *KidCare* program. But it faced considerable challenges

moving from a relatively small school-based program operating in only a third of Florida's 67 counties, to a statewide program that would cover children of all ages and include Medicaid as well as SCHIP.

The Department of Health was given responsibility for administering and coordinating *KidCare* outreach, with an outreach budget of roughly \$8.9 million during the state fiscal year (July through June) 2001-2002. State funding for *KidCare* outreach comes from various sources; for state fiscal year 2001-2002, welfare reform programs (PROWRA 90/10 and TANF reserve) contributed the largest share (\$3.7 million), tobacco settlement funds (\$1.1 million), federal refugee funds (\$1 million), and an administrative trust fund (\$0.2 million). In addition, the RWJ Covering Kids Initiative provided \$2.7 million.

The Lawton and Rhea Chiles Center (named for the late former U.S. Senator from and Governor of Florida, Lawton Chiles), a research and advocacy organization at the University of South Florida, assists the Department of Health by facilitating interagency workgroup meetings and conducting ad-hoc studies. Regional outreach centers coordinate local outreach efforts. As in other states, Florida's outreach efforts have evolved over time to place a greater emphasis on local and regional approaches to find and engage hard-to-reach populations.

B. STATEWIDE MEDIA EFFORTS

Statewide campaigns were used to a small extent under *Healthy Kids* but have played a larger role in *KidCare*. The primary goals of the statewide *KidCare* outreach campaign have been to establish a clear identity for the new *KidCare* program, and to ensure that the infrastructure is adequate to respond to interest generated through promotional efforts. The primary slogan used to promote the program is "*KidCare*: Child Health Insurance You Can Afford," and the message "For Parents, One Less Worry" is also widely used in *KidCare* posters

and other promotional materials. Key elements of the state-level strategy are outlined and described briefly below.

- ***Program Name/Identity.*** The decision to integrate Medicaid and SCHIP under the *KidCare* umbrella was made by the Florida legislature and contained in the authorizing legislation for the Phase II expansion. In building name recognition for *KidCare*, legislators wanted to create a new identity for publicly-funded child health programs, reduce the stigma sometimes associated with Medicaid, and also build on positive images already associated with *Healthy Kids* and *CMS*.
- ***Media Campaigns.*** Advertising on television and radio, billboards and bus cards occurred throughout the year and especially during the initial months of the school year. In addition to building awareness about *KidCare*, the ads stressed the value of having health insurance and the importance of remaining insured once enrolled.
- ***Toll-free Telephone Hot Lines.*** The existing *Healthy Kids* hotline was expanded in April 1998 to serve as the main *KidCare* hotline. The toll-free phone number was placed on the *KidCare* application and on *KidCare* promotional materials. *Healthy Kids* also continued to operate a customer service line to address specific questions and concerns about that program.

The *KidCare* hotline soon became overwhelmed by the large volume of calls stimulated by *KidCare* outreach and calls inquiring about the status of applications. Responsibility for the main *KidCare* hotline was subsequently transferred to the Department of Health, as originally mandated in the legislation, and additional hotlines were introduced to handle program-specific questions. Eventually, five different hotlines served the *KidCare* program:

- The main *KidCare* hotline, operated by a third party administrator and overseen by the Department of Health
- The *Healthy Kids* customer service line
- A new Medicaid hotline, the first ever operated by the Department of Children and Families, to address questions about the status of Medicaid eligibility determinations
- Another Medicaid hotline, operated by a third party administrator, to help families select (or change) a health plan and a Primary Care Provider (PCP)
- A new hotline for the *MediKids* program, administered by the Agency for Health Care Administration, to help families select a managed care provider

(health maintenance organization or primary care case management (PCCM) program).

At the time of the site visit, the *KidCare* partner agencies agreed that the hotline system had become too complex, and the group had already met to discuss streamlining and reducing overlap across the various hotlines. The *Healthy Kids* program had already transformed its customer service line into an outgoing call center to welcome families to the program and support retention (discussed further in Chapter IV).

- **Web Page.** The Florida *KidCare* application and a variety of reports and other program information can be downloaded from the program's webpage. *Healthy Kids* also operates a website with links to *KidCare* along with reports and information about the *Healthy Kids* program. Both sites are very colorful and easy to navigate. They are set up to support the needs of families, state and local program staff, providers, researchers, advocates, and others. To help regional outreach coordinators target local outreach efforts most effectively, the Chiles center assembled and posted on the *KidCare* web site region-specific estimates of the number of uninsured children along with figures on the number of children enrolled in *KidCare*.
- **Print Materials and Promotional Items** (posters, brochures, fliers, fotonovelas). The state produces and distributes a variety of print materials, which can also be ordered from the program's webpage. Program materials use bright colors and photographs, and have been refined over time to reflect lessons learned from focus groups and marketing consultants. Individual *KidCare* components also produce and distribute materials tailored for families and/or providers. Local projects may also develop materials with messages tailored appropriately for a particular community. Locally-developed materials must be approved by the state, and a checklist is used to ensure that all materials include certain required messages and that the language used is appropriate.
- **Support for Regional Outreach Projects.** To coordinate local outreach efforts, the state established regional outreach centers throughout the state. Initially the state established 30 projects but funding cuts led to a scaling back to 17 projects. Most projects are based in a local health department, though community based organizations operate projects in some regions. State funds are allocated across the projects based on the region's share of low-income children. State staff provide materials, conduct training sessions, and serve as a general resource for *KidCare* regional outreach coordinators. To leverage limited resources, regional coordinators have been encouraged to identify and train local partners who can assist in getting the word out to families, especially the hard-to-reach.

In addition to the general *KidCare* outreach, the *Healthy Kids* and *CMS* programs target outreach to children eligible for these programs. *Healthy Kids* works primarily with schools, while *CMS* builds relationships with providers and agencies serving children with special health care needs. Referrals to *CMS* come in from hospitals and other health care providers, early intervention programs, vocational rehabilitation programs, the social security administration (for SSI beneficiaries), and from Medicaid and *Healthy Kids*. The Behavioral Health Specialty Care Network (BHSCN) also produces special brochures and posters for health care providers and agencies working with emotionally disturbed children.

C. COMMUNITY-BASED EFFORTS

As in other states, most of the effort to find and assist *KidCare*-eligible families occurs at the local level, under the direction of the regional outreach coordinators. Regional outreach projects promote *KidCare*, make applications available, and to some extent help families complete the application and navigate the enrollment process. Outreach strategies vary from region to region. Common approaches include making presentations at schools, participating in health fairs, meeting with groups of parents or providers, and distributing applications, brochures, posters, fliers and other materials in a variety of community locations. Local outreach efforts have become more specialized as the program has matured and word has gotten out to “mainstream” populations. Recent efforts are focused more heavily on finding harder-to-reach populations. Fotonovelas—booklets formatted like a comic book with pictures of real people and more serious storylines—are thought to be an especially effective strategy for reaching Hispanic and migrant populations.

There is not a formal application assistance program in Florida. Regional outreach projects that decide to devote time and resources to this activity are doing so with their outreach funds or funding secured from other sources. In Broward County, the regional coordinator developed

instructions for the application because many of the families she works with have trouble understanding the limited instructions included in the application. The coordinator reported spending “a lot” of one-on-one time helping families complete the application. The North Broward Hospital District in Broward County decided to fund a pilot project on their own to assess the benefits of providing additional assistance with the application process. After several months of providing such support, outreach staff reported that they believe their efforts have significantly increased the number of applications submitted and approved. The hospital district agreed to fund the pilot project because they hoped that it would help reduce their spending on indigent care. Still, District officials expressed frustration with the state’s unwillingness to support a more formal community-based application and enrollment assistance component.

School-based strategies are central to local *KidCare* outreach in Florida. As it has done for years, the Florida Healthy Kids Corporation distributes applications and other promotional materials in student backpacks at the beginning of the school year. School systems fully support this effort, helping with the distribution and fielding questions from families. The school contribution can be substantial. In Broward County, for example, the school district assumed full responsibility for distributing 320,000 applications, which required hiring additional staff. Outreach staff noted that the backpack distribution works especially well for younger children, and that for middle school and older students other strategies are also sometimes employed to ensure that applications actually get to the parents. In addition to the initial distribution, applications are made available in schools throughout the year from front office staff, school nurses, and guidance counselors.

Many organizations assist in getting promotional materials and applications in the hands of eligible families. In addition to schools, these include child care providers, clinics, hospitals and other health care providers, religious organizations, and organizations working with immigrants

and other special populations. In Broward County, a program for refugee families has been very successful in helping families apply for *KidCare*, and in helping to resolve problems they encounter when children are incorrectly deemed ineligible. The Broward County outreach center has also focused recent efforts on migrant populations and employees in small businesses that do not offer dependent coverage. Outreach staff have also worked with local welfare-to-work agencies to reach families eligible for Medicaid or SCHIP. RWJF-funded Covering Kids outreach projects operated in 6 Florida counties: Duval, Dade, Broward, Pinellas, Heartlands, and Palm Beach.² Covering Kids has formed an outreach coalition comprised of advocates and *KidCare* representatives throughout the state which is chaired by the Secretary of the Department of Health.

To help regional and local outreach staff target their outreach effectively, the Department of Health contracted with ICHP to produce monthly reports showing the number of applications received by county, along with demographic information about the pool of applicants and a summary of common problems with the applications (such as missing data). This information is posted on the *KidCare* webpage, and regional coordinators use it to monitor their progress and identify priority areas for future outreach.³

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Enrollment in Medicaid and SCHIP has grown steadily since *KidCare* was launched in Spring 1998, and the volume of applications coming into the program continues to grow each year. Many thousands of applications were distributed in community locations throughout the

²While specific activities vary from one project to another, the overall goal of the Covering Kids initiative is to increase enrollment in Medicaid and SCHIP.

³These reports are available at [<http://www.floridakidcare.org/outreach/data.html#Data>]

state. In all, 176,647 applications were submitted in 2002 (about 14,700 per month on average) (Shenkman and Bono 2003).

Annual surveys of new enrollees conducted by ICHP indicate that families are most likely to learn about the program from the schools, their doctor, and their family and friends (Shenkman and Bono 2003). In the most recent survey, conducted in August through December 2002, nearly 60 percent of *Healthy Kids* enrollees heard about *KidCare* through the schools. Word-of-mouth is another very effective method for promoting the program—from about 55 to 60 percent of enrollees in *Healthy Kids*, Medicaid and *MediKids* learned about *KidCare* from friends or family members. The survey also found that providers are a very important source of information about *KidCare*, especially for children with special health care needs. *KidCare* outreach staff reported that word-of-mouth is the best way to reach families, especially in rural areas and communities with larger concentrations of immigrants or non-English-speaking populations. In a one-on-one encounter, staff added, you can not only raise awareness about the program but also answer questions and address misconceptions families may have about their eligibility.

While legislators expected—and hoped for—an increase in Medicaid enrollment because of *KidCare* outreach, the increase has been larger than anticipated. As one informant from the state legislature noted, “I think for every child brought into Title XXI, two are added to Medicaid.” State officials attribute most of this increase to *KidCare* outreach efforts, noting that very little had been done to promote the Medicaid program prior to *KidCare*. Several informants expressed concern that the large increases in Medicaid and SCHIP enrollment, together with the state’s current fiscal problems, could lead to reduced support for outreach in the future.

Recognition of the *KidCare* name has reportedly grown over time, but many families continue to identify more strongly with individual program components (especially *Healthy*

Kids, Medicaid, and *CMS*). Key informants also noted that some families are confused about how the different program components relate to one another.

According to many informants, the scale and reach of the *KidCare* program overwhelmed the capacity of the telephone hotline and eligibility determination systems in the first year or so of *KidCare*. At first, *KidCare* marketing campaigns were broadly focused and conducted in many media markets at the same time. This resulted in large numbers of applications coming into the system simultaneously, overloading eligibility and enrollment processes and causing long delays and even the loss of some applications. The initial statewide marketing campaigns also did not adequately account for the fact that *Healthy Kids* was not operational in every county until January 2000. Campaigns generated inquiries from families in communities where *Healthy Kids* was not yet operational, causing confusion and frustration among parents. All of this undermined early efforts to build a positive image for the new *KidCare* program.

To remedy these problems, Florida modified its outreach and marketing so that major campaigns would be staggered over time and across regions. They found this phased approach to be much more effective than large-scale media “blitzes.” Even the distribution of applications in the schools is now staggered throughout the fall rather than all at once at the beginning of the school year. Promotional materials were also modified to make it clear that families should check to see if a particular program is available in their area.

Focus groups with families have helped program staff shape the messages the program uses. They have learned, for example, that terms like “free” or “low cost” may imply that the program is “cheap” or low quality, and that families respond more positively to phrases like “Child Health Insurance You Can Afford,” and “One Less Worry.” Some ads, staff discovered, work well for some groups but not others. The state also followed through on a recommendation from local outreach staff to replace the plain white *KidCare* application envelopes with a bright yellow

color that would draw more attention to application displays in physician offices and other community locations. The state has engaged a consultant to evaluate the hotline configuration.

Although the *KidCare* hotlines had significant problems during the program's early years, they have since improved substantially. During the early stages of the program, many informants reported hearing from parents about having to wait 30 minutes or more to get through to someone on the main *KidCare* hotline. However, Shenkman and Bono (2003) documented substantial improvements in the hotlines' functioning. For example, they found that from 83 to 89 percent of families in state FY 2001-2002 who used hotlines were "able to reach someone at the toll-free number easily." This was a statistically significant improvement over state FY 2000-2001 when from 71 to 80 percent of families were able to do so.

Local outreach staff noted that significant challenges remain in reaching immigrant populations. A large number of non-citizen children are income eligible but cannot participate in *KidCare* because of federal restrictions. Outreach staff also noted that concerns about public charge and deportation are major barriers in some parts of the state. Several informants described an incident that had taken place in South Florida, where INS officials raided a *KidCare* presentation involving local immigrants. Word about this event spread quickly among immigrant communities, seriously undermining *KidCare* outreach efforts. Regional outreach staff in Broward County decided to modify materials produced by the state after learning that many families they work with wanted more specific information about immigrant eligibility as well as cost-sharing provisions. At the time of the site visit, outreach staff in Okeechobee had been trying to get permission from tribal leaders to meet with parents on a local reservation but had not yet been successful. Finally, local outreach staff also expressed frustration with the lack of state support for community-based application assistance. They have found that many families need help completing the application, especially non-English-speaking populations.

IV. ENROLLMENT AND RETENTION

A. POLICY DEVELOPMENT

In designing *KidCare*, legislators and program officials were keenly aware of the need for a simplified and coordinated application and enrollment process. Many perceived the Medicaid eligibility determination process in place at that time to be problematic. Families applying for Medicaid were expected to participate in long face-to-face meetings at local DCF offices, complete a lengthy application form,⁴ and produce numerous documents verifying information in the application. *KidCare* provided an opportunity many felt was long overdue to simplify the Medicaid process, but creating an integrated system to support Medicaid and other *KidCare* components would be challenging. In addition to designing a common application form, they would need to modify existing data systems, develop procedures for transferring and sharing information among the various program partners, and develop systems for assisting and communicating with applicant families. All of this would need to happen quickly to meet the Governor's goal of being one of the first states to implement SCHIP.

The most significant challenges involved reconciling Medicaid's more complex requirements and procedures with the simplified approach in place for *Healthy Kids*. Further challenges stemmed from Title XXI's "screen and enroll" requirements, the need for medical screening for the *CMS* network components, and different rules about how income is computed, whether and how cost sharing is imposed, and how health plans and/or primary care physicians

⁴At that time the Medicaid application was roughly 12 pages. Prior to completing the application—known as a Request for Financial Assistance, or RFA—applicants would typically fill out a one-page screening form that DCF staff would use to estimate the amount of time needed for subsequent appointments, and to identify the documents the family would need to bring to these meetings.

are selected. Systems in place under *Florida Healthy Kids* provided both a model and a structure that would help the state get its program up and running quickly. With the application, for example, they were able to start with the one-page (2-sided) *Healthy Kids* application, adding to and otherwise adjusting it to accommodate the needs of the other programs (mainly Medicaid and *CMS*).

B. ENROLLMENT PROCESS

The *KidCare* enrollment process is designed to make it as easy as possible for families to apply and become enrolled in the appropriate program component. Important elements that allowed the partners to achieve this goal include the simplified common application form, and expansion of a mail-based application process. Several policy changes were needed to make this happen:

- Eliminating Medicaid requirements for face-to-face interviews at local Department of Children and Families offices
- Ensuring that the application would obtain information needed to compute income under Medicaid and SCHIP components⁵
- Eliminating the asset test under Medicaid
- Eliminating Medicaid requirements that applicants provide documents to verify income and other information
- Re-engineering of the “FLORIDA” eligibility system for Medicaid

As shown in Table IV.1, eligibility policies across the different *KidCare* components are now quite similar. The most notable differences are that Medicaid eligibility is retroactive, covering medical expenses incurred 90 days prior to receipt of the application, while eligibility

⁵Different rules are used to compute income under Medicaid and SCHIP in Florida—with Medicaid including only the income of parents or caregivers with financial responsibility for the child, and SCHIP including the income of household members who may not contribute to the child’s support.

TABLE IV.1
SCHIP ELIGIBILITY POLICIES

Policy	Medicaid Expansion	<i>MediKids</i>	<i>Healthy Kids</i>	<i>Children's Medical Services Network</i>
Retroactive eligibility	Yes	No	No	No
Presumptive eligibility	No ^a	No ^a	No ^a	No ^a
Continuous eligibility	12 months ^b	6 months	6 months	6 months
Income test	Net	Gross	Gross	Gross
Asset test	No	No	No	No
U.S. citizenship requirement	Yes ^c	Yes ^c	Yes ^c	Yes ^c

SOURCE: State of Florida. "Florida KidCare Program: Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Health Care Financing Administration." July 2000.

SCHIP = State Children's Health Insurance Program

^aFlorida's Title XXI legislation contains language permitting "expedited" eligibility for *KidCare* (Title XXI) components (that is, *Healthy Kids*, *MediKids*, *CMS*, and the Medicaid expansion), which authorizes each of the *KidCare* partners to "seek innovative measures to speed up the eligibility process" (State of Florida 2000).

^bChildren under age 5 only.

^cQualified aliens are also eligible for SCHIP benefits.

for the other program components takes effect after eligibility is established (and, where applicable, premiums are received). Also, Medicaid eligibility for children under age 5 is extended continuously for 12 months, whereas older Medicaid children and Title XXI populations are guaranteed 6 months of continuous coverage. None of the *KidCare* components use an asset test in eligibility determination. The *KidCare* (Title XXI) legislation does not offer

presumptive eligibility, but it does authorize “expedited” eligibility for each of the *KidCare* (Title XXI) components, which allows the *KidCare* partners “to seek innovative measures to speed up the eligibility process” (State of Florida 2000).

The *Healthy Kids* program allows families with incomes above 200 percent of FPL to purchase coverage for their children by paying the full premium amount. To minimize adverse selection and control state spending on this population, the *KidCare* legislation stipulates that enrollment in the buy-in components must not exceed 10 percent of total enrollment. There is no buy-in component under *MediKids* or *CMS*, but children with special health care needs in families with incomes above 200 percent of FPL may enroll in *Healthy Kids*.⁶ Furthermore, there are no spend-down provisions under *CMS* for Title XXI populations, limiting that program’s ability to cover children with special health care needs in higher-income families. *CMS* officials reported that many children with special health care needs quickly exceed the one-million-dollar lifetime coverage limit under *Healthy Kids*.

Joint and simplified application. Initially, the Florida Healthy Kids Corporation took the lead in coordinating the inter-agency development of a common application form that would also be easy for families to complete. An improved simplified *KidCare* application was targeted for distribution in early 2003. As noted in Table IV.2, the joint application was two pages long, printed on both sides of a legal-size form. Printed versions are available in English, Spanish, and Creole. It can be downloaded off the program’s web-page, and the Department of Health also works closely with the regional outreach coordinators to ensure that applications are available in many community locations. Although those involved in developing the application view it as

⁶Florida’s *KidCare* legislation allows for a buy-in component under *MediKids*, but it has not been implemented.

TABLE IV.2

APPLICATION FORM, REQUIREMENTS AND PROCEDURES
FOR THE FLORIDA *KIDCARE* PROGRAM

Characteristic	
Form	
Joint Form	Yes
Length	2 pages
Languages	English, Spanish, and Creole
Verification Required from Applicants	
Age	No
Income	No
Deductions	No
Assets	No
State Residency	No
Immigration Status	No
Social Security Number	No
Enrollment Procedures	
Face-to-face Interview Required	No
Mail-in Application	Yes
Phone Application	No
On-line Application	No ^b
Hotline	Yes
Outstationing	Yes
Community-Based Enrollment	No

SOURCE: State of Florida. “Florida KidCare Program: Amendment to Florida’s Title XXI Child Health Insurance Plan Submitted to the Health Care Financing Administration.” July 2000.

^aIncludes all children age 0-19 in Title XIX and Title XXI.

^bThe Florida Healthy Kids Corporation is piloting an online application process.

self-explanatory, brief instructions are provided on the form itself. Families applying for more than one child complete only one application—there is space on the form for information on up to three children, and families may attach information on additional children. The application requests information about parents or guardians who live in the household with the child(ren).

Parents and guardians are asked to provide address and contact information, their social security number and the name of their employer. Although the application does not indicate that the social security number is optional for parents and guardians, the separate tri-fold brochure about the *KidCare* program that is distributed with the application makes this point in a short section on “How to Apply.” For applicant children, social security numbers are required.

Other information required for each child includes: whether or not they are a U.S. citizen (and if not, date of entry into the U.S.), their relationship to each parent or guardian listed on the application, whether or not they currently have health insurance, and if so the name of the health insurer, and whether or not the child “has a medical or developmental condition expected to last more than 12 months.” This latter item is included as a screening question to assess potential eligibility for the *CMS* network. Because some families misunderstood the purpose of this question, language was added to the tri-fold brochure clarifying that applications will not be rejected if a family checks this box.

Remaining sections of the application include a few more questions about household members and gather information about income and day care expenses. The application also explains the *KidCare* premium provisions and suggests that applicants for any program other than Medicaid include with their application a check or money order for the minimum \$15 premium payment. Finally, applicants are asked to indicate their preferred language for written materials (English, Spanish, or Creole), and how they heard about *KidCare* (school, friend/family, TV/radio, newspaper, health care provider, other).

Applicants are not required to document information contained in the application. Some information (income, state employment) is verified using state databases. An important factor in the decision to eliminate formal verification requirements was the experience of the *Healthy Kids*

program. *Healthy Kids* had always relied on self-reported information, and in validation studies they had found the information to be accurate in a high percentage of applications.

Screening and eligibility determination. Families apply for *KidCare* coverage in one of two ways: by mail or through a local DCF office (see Table IV.3). Families applying for cash assistance, food stamps, and/or Medicaid coverage for adults in addition to coverage for children must apply through a local DCF office, and these families complete the longer Request for Assistance (RFA) application. Families applying only for children's medical coverage complete a *KidCare* application and either mail it in themselves or submit it to their local DCF office (and DCF mails it to the Florida Healthy Kids Corporation). At the time of the site visit, FHKC was piloting an online application process that, if successful and accepted by the other *KidCare* partners, would provide another avenue for submitting *KidCare* applications. The online system is being tested in five different locations: a local health department, a school, a hospital, and two community based organizations that work with hard to reach populations. Several *KidCare* partners expressed concerns that FHKC had not involved the other *KidCare* partners in the pilot program, though it was unclear whether this would influence decisions about adopting the online system.

The vast majority of *KidCare* applications are mailed in to the Florida *Healthy Kids* Corporation (FHKC) headquarters in Tallahassee. Each day, FHKC staff count the applications received, select a sample to be monitored for QA purposes, and forward the applications to a third party administrator (TPA). The TPA then sends each family a letter acknowledging that the application was received. If important information is missing from the application, the TPA sends another letter requesting that this information be submitted.

TABLE IV.3

REDETERMINATION FORM, REQUIREMENTS AND PROCEDURES

Characteristic	<i>Healthy Kids, MediKids, CMS</i>	Medicaid
Same Form As Application	Yes	Yes
Pre-Printed Form	Yes	No
Mail-In Redetermination	Yes	No (face-to-face interview required)
Income Verification Required	No	Yes
Other Verification Required	No	Yes

SOURCE: State of Florida. “Florida KidCare Program: Amendment to Florida’s Title XXI Child Health Insurance Plan Submitted to the Health Care Financing Administration.” July 2000.

The TPA screens each application to determine if children are potentially eligible for Medicaid, MediKids, the CMS Network, or Healthy Kids. As outlined below, DCF makes Medicaid eligibility determinations and the TPA determines eligibility for the other KidCare components.

- **Potential Medicaid Eligibles.** For children screened as potentially eligible for Medicaid, the TPA sends applications electronically to the DCF *KidCare* Unit in Tallahassee. DCF staff from this unit are co-located at FHKC to facilitate the processing of these applications. The DCF computer system then checks to see if the applicant is already in the system because of previous or current receipt of public assistance.⁷ If so, the application is forwarded to the local DCF office responsible for that case. Other potentially eligible cases are forwarded to one of four regional processing units, where DCF eligibility staff gather remaining missing information and conduct a simplified eligibility determination. If the child is determined to be Medicaid eligible, DCF notifies the *KidCare* TPA, sends a letter to the family, and forwards the case to the appropriate local DCF office where the case is then managed

⁷Notably, the computer system DCF uses to administer Medicaid, food stamps, and cash assistance programs (known as the FLORIDA system) cannot communicate electronically with the other *KidCare* computer systems, so the state has had to introduce additional data entry steps to permit the exchange of information between the different systems. Automated files sent from the TPA to DCF are imported into a new system at DCF known as KISS (*KidCare* Information Selection System) that is set up to track applications that come in from the TPA and to extract certain variables that can then be imported into the FLORIDA system.

over time. If the child is not eligible for Medicaid, DCF notifies the TPA, which then assesses the child's eligibility for other *KidCare* components.

- ***Other Potential KidCare Eligibles.*** For applicants screened potentially eligible for *MediKids*, *Healthy Kids*, or *CMS* (and *KidCare* applicants determined to be ineligible for Medicaid), the *KidCare* TPA determines eligibility. The TPA reviews available state databases to determine whether the application should be rejected because the child is already covered by Medicaid or is a dependent of a state employee. When these steps are completed, and the TPA has received any missing information and, as applicable, results from *CMS* medical eligibility determinations, applicants are either enrolled in a *KidCare* component or rejected. Premium payments must also be received before enrollment will take effect, though many families include the first month's premium payment with the application, as advised on the application.
- ***CMS Network Eligibles.*** In addition to the determinations made by the *KidCare* TPA or DCF, the *CMS* program determines medical eligibility for the *CMS* network. Applications for children screened as potentially *CMS*-eligible are sent to the *CMS* program.⁸ *CMS* then follows up with families to gather additional information needed for the medical assessment. When *CMS* has completed its determination, it notifies the *KidCare* TPA.

C. REDETERMINATION PROCESS

Florida uses a passive redetermination process for the *Healthy Kids*, *MediKids* and *CMS* programs. Before the end of the 6-month continuous eligibility period, the *KidCare* TPA mails families a preprinted form containing the information submitted in the family's original application (or in the most recent update provided to the program). Families are asked to correct and return forms to FHKC. If there are no changes, families do not need to send back the form. If the form is not returned, the program assumes that the family's status has not changed.

The redetermination process for Medicaid differs from the other *KidCare* programs. Every 12 months (or 6 months for children over age 5), families are required to complete an application form and meet with a caseworker at their local DCF office. Prior to the end of the eligibility

⁸The *KidCare* application includes a *CMS* network-screening question that asks if the child has a medical or developmental condition expected to last more than 12 months. The TPA forwards to the *CMS* program all applications that include a yes response to this question.

period, DCF sends the family a letter and an application form (either the *KidCare* application or the RFA, depending on what the family used to apply initially). Families are expected to complete and return the form, and to call and set up an appointment with their caseworker. DCF terminates enrollment if it does not receive the form by the due date. There is currently little coordination between Medicaid and the other *KidCare* components at the point of redetermination.

In November 2000, *Florida Healthy Kids* introduced an outgoing call center that has proven to be very effective in increasing retention. *Healthy Kids* decided to test a new customer service program. Phone center staff now make welcome calls to new enrollees, and also call each enrollee on their birthday. In addition to addressing questions and concerns about the program, phone center staff encourage enrollees to get to know their primary care physician and to schedule preventive care appointments. They tested the program for 9 months, randomly selecting enrollees to receive calls as well as a control group who did not receive calls. While program staff expected to see an increase in customer satisfaction, and they did, they were somewhat surprised to learn of its positive impact on retention. Compared with the control group, they discovered that those receiving the calls stayed in the program an average of 5 additional months and were 30 percent more likely to make their premium payments on time. The new call center, which came to be named the “retention center,” became a permanent part of the program during the Fall of 2001.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

By all accounts, Florida has been very successful in enrolling and retaining eligible children under *KidCare*. As shown in Table IV.4, Title XXI enrollment has grown steadily each month, from 1,526 in April 1998 to over 281,000 in December 2002. Enrollment in Title XIX programs

TABLE IV.4

ENROLLMENT TRENDS: CHILDREN IN *KIDCARE*

Enrollment Measure	April 1998	1998	1999	2000	2001	2002
Number of children ever enrolled in federal fiscal year (October through September)			154,594	227,463	298,705	368,180
Number enrolled at a point in time (December, unless otherwise noted)	1,526	55,019	125,938	188,664	247,270	281,269
Percent change in point-in-time enrollment		+3,505%	+129%	+50%	+31%	+14%

SOURCE: Centers for Medicare & Medicaid Services, "State Children's Health Insurance Program (SCHIP) Preliminary Annual Enrollment Report for Federal Fiscal Year (FFY) 2002"; Available online at [www.cms.gov/schip/schip02.pdf]. Accessed: February 27, 2003.

Centers for Medicare & Medicaid Services. "State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 states and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999." Available online at [www.cms.gov/schip/fy99-00.pdf]. Accessed: March 3, 2002.

State of Florida, Agency for Health Care Administration, "Statewide Trends in *KidCare* Enrollment." Available online at [www.floridakidcare.org/outreach/downloads/state-trends.pdf]. Accessed: February 27, 2003.

NOTE: SCHIP (Title XXI) components only.

for children also increased during this time period by about 415,000, bringing total enrollment to over 1.1 million children by December 2002 (State of Florida 2002).

KidCare applications continue to come in steadily as well, with 176,947 applications submitted during the state fiscal year 2002 (July 2001 through June 2002), an increase of 10 percent over the previous year (Shenkman et al. 2002, Shenkman and Bono 2003). Of the 281,269 enrolled under Title XXI components in December 2002, 240,335 were enrolled in *Healthy Kids*, 31,426 in *MediKids*, 1,453 in the Medicaid expansion⁹, and 8,055 in *CMS*.

While Florida's enrollment levels have grown steadily and reached impressive levels by the end of 2002, they had yet to reach the target enrollment levels established by the state legislature, and the target numbers used to generate the state's Title XXI allotment. Advocates and some providers we met were concerned that the state was not accessing its full federal allotment, especially because Florida was ahead of other states at the start because of its grandfathered *Healthy Kids* program. State program officials, however, explained that the following were among the factors that have influenced enrollment trends in Florida:

- Most important, it took time (more than expected) to expand *Healthy Kids* to every county in the state. Also, roughly 15 percent of children enrolled in the pre-SCHIP *Healthy Kids* program were transferred to Medicaid after Title XXI took effect, in accordance with Medicaid screen and enroll provisions.
- The *MediKids* program was brand new, and getting the word out about this component required development and testing of new marketing strategies. Furthermore, enrollment in *MediKids* was limited at first because of open enrollment periods required by state law (open enrollment periods during the first year were limited to 3 months at the start of the program and 2 additional one-month periods later in the year). Since then, enrollment in *MediKids* has been permitted continuously throughout the year.
- Florida's local match requirements also affected enrollment levels in some areas. When the local match component was in effect, enrollment was essentially frozen in counties that had not contributed their local match.

⁹All of the children in the Medicaid expansion are infants—teenage children aged out of the program in October 2002.

- The uninsured estimates used to calculate Florida's SCHIP allotment include a large number of undocumented individuals who are not eligible for *KidCare* under federal law, potentially causing the allotment to be overestimated. Several state officials cited figures from a state-sponsored analysis indicating that 85 to 87 percent of the *KidCare* eligible population had already been reached.

Key informants reported improvements in the application and enrollment processes over time by overcoming serious problems during the first 18 months or so after *KidCare* was launched. During those early months, systems could not handle the large volume of *KidCare* applications. Applications became backlogged and many families waited three months or longer before coverage became effective. The *KidCare* hotline was overwhelmed as families called to find out the status of their applications, and families were left on hold for long periods of time. The backlog was especially great for Medicaid eligibility determinations. As a DCF state official described, about a year prior to the site visit (Fall of 2000) there were roughly 30,000 *KidCare* applications pending Medicaid eligibility determinations, and 3,000 of them had been pending for more than 45 days. In contrast, at the time of the site visit only 6,000 *KidCare* applications were pending and only 42 had been pending for more than 45 days.

The Institute for Child Health Policy's findings confirm that the application and enrollment processes have improved over time. A range from 50 to 70 percent of families reported positive experiences with the toll-free phone line in 1999, compared to a range of 83 to 89 percent in 2002 (Shenkman et al. 2000; Shenkman and Bono 2003). Family members of new enrollees were also asked about the amount of time they had waited between when they applied and when their coverage took effect. The percentage of new enrollee families reporting wait times longer than two months declined from 46 and 43 percent for *MediKids* and *Healthy Kids* enrollees surveyed in 1999, to 24 and 15 percent, respectively, among those surveyed in 2002 (Shenkman and Bono 2003). In addition, the 2002 survey found that most families in *MediKids* (71 percent),

Healthy Kids (72 percent), and *CMS* (71 percent) felt they were kept well informed about the status of their application.

Florida took advantage of opportunities provided through SCHIP to simplify and streamline the Medicaid application and enrollment process. The “spillover” benefits of SCHIP for Medicaid include a much shorter application for child-only coverage, a mail-only application avenue, and a simplified, speedier determination process. Another spillover effect for Medicaid is the enhanced outreach and awareness-building efforts it benefits from as a result of being included as a *KidCare* program component.

The eligibility determination process is lengthier for *CMS* because of the additional steps required to assess a child’s medical status. Another factor increasing the processing time is the large number of applications received by *CMS* for children who end up not being eligible. Using the current single-question approach, roughly 7 percent of *KidCare* applications are referred to *CMS*, and 32 percent of children referred to *CMS* for eligibility determination meet the medical criteria for inclusion in the *CMS* network. *CMS* pushed for better screening questions on the application that would reduce the number of ineligibles assessed.¹⁰ The updated application targeted for early 2003 contains the improved screening questions.

Throughout 2002, the *KidCare* partners met in work groups to review the content of the application and identify areas for improvement. In addition to replacing the *CMS* screening

¹⁰A preliminary assessment of the effectiveness of other screening tools suggests that the screening tool known as the Living with Illness Measure, or LWIM, would reduce significantly the number of applications referred to *CMS* for children ultimately determined to be ineligible under *CMS* (Wegener and Shenkman 2000).

question, partners were interested in obtaining information about race and ethnicity from the application. In the past, FHKC resisted changing the application to avoid increasing its length.¹¹

Officials of the Behavioral Health Specialty Care Network (BHSCN) expressed concern about the limited number of enrollment slots available under this component. Based on research suggesting that five percent of a given population of children would have more serious behavioral health conditions, as many as 5,000 children enrolled in *Healthy Kids* would potentially qualify for their network. Only halfway through state fiscal year 2001-2002, BHSCN had nearly met its caseload limit of 303 enrollees. As of November 2001, slots had been distributed equally across BHSCN's 16 districts, even though demand varied greatly from one district to another. In the near future the program hopes to implement an approach to distributing slots that is based more closely on demand.

Florida's experiences with retention under *KidCare* are mixed. On the one hand, the passive redetermination approach appears to have reduced the number of otherwise eligible children becoming disenrolled because paperwork is not completed in time. According to a recent study that examined retention rates under *KidCare* and four other SCHIP programs, disenrollment under *Healthy Kids*, *MediKids* and *CMS* occurs at a fairly stable rate throughout the year, below five percent in most months, and these *KidCare* programs do not experience the periodic spikes in disenrollment seen in states with traditional redetermination processes (Dick et al. 2001). The new outgoing call center has also helped to improve retention in the *Healthy Kids* program. But many children are still being disenrolled from *Healthy Kids*, *MediKids* or *CMS* because of premium non-payment. As reported in ICHP's fourth evaluation report, disenrollment from

¹¹Another factor in recent months has been that the TPA is implementing improvements to its computer and monitoring systems required under its new contract with FHKC. FHKC believed that changes to the application could have complicated the transition and caused service disruptions.

Healthy Kids, MediKids and *CMS* during Florida's fiscal year 2002 totaled 71,027, or roughly 19 percent of total enrollment (Shenkman and Bono 2003). ICHP's survey of *KidCare* disenrollees in 2002 indicated that, among disenrollees from the *Healthy Kids* and *MediKids* programs, 41 percent transferred to Medicaid and 13 percent left the program due to premium nonpayment.

Many state and local informants recommended improved coordination between Medicaid and SCHIP redetermination and disenrollment procedures. Ideally, informants noted, the programs should help families to maintain continuous coverage. For example, informants noted that when Medicaid redetermination forms are mailed out, a *KidCare* application should be included so that families can apply if their income or other circumstances have changed—rather than having to initiate that process on their own after their Medicaid coverage ends. And while Medicaid may not be able to adopt the same passive redetermination process used for *Healthy Kids, MediKids* and *CMS* (because premiums are not imposed under Medicaid), many informants suggested that states communicate more clearly with families, eliminate face-to-face interviews, and introduce other simplification steps to improve the Medicaid redetermination process. Another weakness key informants noted about the Medicaid system is that it is not easy for families to provide updated address and other contact information. Consequently, children may remain enrolled in the program (and premiums paid to health plans on their behalf) even after the family has moved out of state. Outdated address information, they added, also reduces the likelihood that families will receive redetermination letters and other program notices. Several informants cautioned, however, that improved continuity of coverage under Medicaid will require additional funding because coverage gaps lower state spending.

Another problem surfaces with the letters families receive. Depending on the circumstances, a family may receive three or four letters during the application and enrollment process from different entities, and informants reported that families are often confused by the

contents. Outreach workers reported that some families say they end up ignoring the letters because they are so confusing. Several informants also noted that the letters are typically written in English, even when families mark on the application that they require materials in another language.

V. CROWD OUT

A. POLICY DEVELOPMENT AND PROGRAM CHARACTERISTICS

Prior to the passage of Title XXI, the *Florida Healthy Kids* program had no provisions designed to prevent “crowd out” (the substitution of public coverage for existing private coverage). In its initial Title XXI plan submission to the Centers for Medicare & Medicaid Services, Florida agreed to assess whether crowd out was occurring under *KidCare*. If the state found evidence of crowd out, it would implement a three-month waiting period for children in the *Healthy Kids* program.¹² Florida’s prior experience with *Healthy Kids* gave state legislators and agency leaders reason to believe that crowd out would not likely be a problem (Shenkman and Wegener 1998). There is currently no waiting period imposed under any of the *KidCare* components. The only requirement is that a child be uninsured at the time of application.

B. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

The general sentiment among those interviewed during the site visit was that crowd out was not occurring to a substantial degree under *KidCare*. They cited two primary reasons that crowd out was more limited in Florida: (1) only a small proportion of low-income workers have access to employer-based dependent health coverage because of the preponderance of small businesses, the large number of self-employed individuals, and the service-based nature of Florida’s economy; and (2) employer-based dependent coverage, when available, is not affordable because of high and rising health insurance premiums. Key informants noted that while families might

¹²The state would not, however, impose a waiting period under *MediKids* and *CMS*, because doing so could jeopardize the health status of these “physically vulnerable” children (State of Florida 2000).

be dropping coverage to enroll in *KidCare*, available employer-based coverage was likely to be unaffordable for many *KidCare*-eligible families.

Surveys conducted by ICHP with family members of new enrollees provide additional insight about potential crowd out under *KidCare* (Shenkman and Bono 2003). Respondents were asked whether their child(ren) had insurance coverage at any time during the 12 months preceding enrollment in *KidCare* (and, if so, the type of coverage they had), and whether the family currently had access to family coverage through an employer (and, if so, the monthly cost to the family for such coverage). While the information on prior coverage does not provide evidence of actual crowd out (because families may have lost coverage prior to enrolling in *KidCare*), it can be interpreted as a high-end estimate of potential crowd out. Roughly 10 percent of families in *Healthy Kids*, *MediKids*, and *CMS* surveyed in 1999 reported having coverage for their children in the 12 months prior to *KidCare* enrollment, and this percentage increased over time to between 25 and 35 percent in 2002 for children in these programs (Shenkman and Bono 2003; Shenkman et al. 2001).

Another source of crowd out occurs when families choose not to make use of available employer-based coverage while enrolled in *KidCare*. Key informants indicated that they had heard of some enrolled families not taking available employer-based coverage because it was unaffordable. Findings from ICHP's survey of new enrollees in 2001 indicate that roughly one-third of families report having access to employer-based coverage while enrolled in *KidCare* (35 percent of *MediKids*, 29 percent of *Healthy Kids*, and 28 percent of *CMS* enrollees) (Shenkman et al. 2002). Over two-thirds of families with access to such coverage reported that it was "too expensive"—families estimated that it would cost an average of 8 percent of their monthly income.

Another ICHP study surveyed disenrollees from *Healthy Kids* and found that 36 percent of the children who left the program did so because their family had obtained other health insurance for the child (Bono et al. 2000). Of these children, 57 percent became covered by employer-based insurance, and 11 percent became covered under other private insurance.

Finally, crowd out may also occur when employers choose not to offer health coverage in response to the availability of *KidCare*. Some key informants noted that while it did appear that fewer employers were offering family coverage, they could not say whether this was due to the availability of *KidCare* or to the rising cost of health insurance coverage.

VI. BENEFITS

A. POLICY DEVELOPMENT

Benefit package considerations played an important role in shaping the design of Florida's SCHIP components. Key informants reported (1) that there was consensus among officials in Florida that the *Healthy Kids* benefit package would be appropriate for most school-age children, and (2) that there was a recognition that younger children and children with more intensive health care needs would require more comprehensive coverage. Furthermore, the state's experiences under *Healthy Kids* had led many to believe that families and health plans alike valued the likeness of the *Healthy Kids* benefit package to private insurance benefits. The state also wanted to prevent large increases in premium payments under *Healthy Kids*, which could happen if the benefit package were expanded significantly.

Benefit coverage under Medicaid was considered much more generous than most private insurance options. Advocates, providers, and many state legislators believed that the Medicaid package, specifically the nearly unlimited coverage available to children under Medicaid's Early and Periodic Screening and Testing provisions, would best meet the needs of younger children and children with special health care needs. In the end, the state opted to go with a "look-alike" Medicaid package for children enrolled in *MediKids* and *CMS*, and to maintain the *Healthy Kids* package for school-age children. Informants from the state legislature noted that there was an interest from the start in including a comprehensive dental benefit in the *Healthy Kids* package, but funding was not available at the time. The dental benefit was eventually added to *Healthy Kids* roughly two years later.

B. BENEFIT PACKAGE CHARACTERISTICS

The *Healthy Kids* benefit package is similar to benefits in most private insurance plans. As one informant noted, “the benefits are designed for the average child.” Florida enhanced the pre-Title XXI *Healthy Kids* benefit package by reducing some of the limits it placed on mental health and substance abuse services. The state kept some service limits: 24 outpatient visits and 60 inpatient days for occupational, speech and physical therapy services, 30 inpatient days and 40 outpatient days for mental health treatment, and 37 inpatient days and 40 outpatient days for substance abuse treatment.¹³ Case management and non-emergency transportation services are not covered. Durable medical equipment and supplies and home health services, however, are covered in full. During the first two years, dental coverage was limited to primarily preventive services in counties that opted to include it. Dental coverage under *Healthy Kids* was expanded in January 2000 and is now comparable to the comprehensive coverage available under Medicaid. Dental coverage was phased in across counties and was available throughout the state by the end of 2002.

The benefit package for children enrolled in the Medicaid expansion component (currently this only includes infants under age 1, since teenage children aged out of the program in October 2002) and in *MediKids* is the same as the standard Medicaid package. The benefit package for children enrolled in *CMS* was described as “Medicaid plus,” with additional coverage provided for early intervention services, parent support (such as family-to-family support groups), respite care, care coordination, genetic and nutritional services.

¹³Detail on service limits was obtained from Hill, Lutzky, and Schwalberg 2001.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

The key informants we interviewed agreed that benefit coverage under *KidCare* is good or excellent. The one problem that had been noted in the past was addressed when a comprehensive dental benefit was added to the *Healthy Kids* package in early 2000. Dental coverage now available under *Healthy Kids*, in fact, was described as being considerably more generous than coverage available through most private insurance plans. Because children with special health care needs are enrolled in the *CMS Network*, key informants reported that limitations on certain services under *Healthy Kids* have not posed significant problems for these families. But while coverage is considered good or excellent under *KidCare*, securing access to some services is a problem because of provider shortages and/or because some providers don't participate. These issues are discussed more in the following chapter.

VII. SERVICE DELIVERY AND PAYMENT ARRANGEMENTS

A. POLICY DEVELOPMENT

In designing the *KidCare* program, state officials built on managed care arrangements already in place under *Healthy Kids*, Medicaid, and *CMS*. *Healthy Kids* had, from the beginning, utilized fully-capitated HMOs exclusively for its delivery system. Medicaid had for many years utilized HMOs, but families were allowed to choose between joining an HMO and participating in a primary care case management (PCCM) program, which in Florida is known as MediPass. Prior to *KidCare*, the *CMS* network coordinated services that were paid for directly by the state Medicaid program on a fee-for-service basis. Under *KidCare*, the delivery systems were continued with only two significant changes. In the case of *Healthy Kids*, the system was expanded to additional counties. In the case of *CMS*, a capitation-based financing element was added. Under *KidCare*, the *CMS* program receives a fixed amount per member per month for children covered under Title XXI, and *CMS* is responsible for paying for as well as coordinating the care these children receive. For children covered under Medicaid, the state continues to pay for *CMS* services directly.

The state decided to create a new delivery system for children enrolled in *MediKids*. The new system would be a hybrid of Medicaid and *Healthy Kids*. Specifically, the program would use Medicaid HMOs or MediPass providers, but would require enrollment in an HMO in counties where at least two HMOs were available. Under Medicaid, families may still choose between an HMO and the PCCM program even when there are multiple HMOs operating in their region.

B. SERVICE DELIVERY SYSTEM

The delivery systems for the various *KidCare* components vary in their use of managed care and the types of managed care arrangements employed. The Title XXI *KidCare* components make more extensive use of managed care, including capitation-based payment arrangements, than Medicaid. Key features of the delivery systems for each *KidCare* component are highlighted below.

- ***Healthy Kids*** requires all participants to enroll in an HMO (in rural counties, the arrangement is with a commercial carrier that operates an Exclusive Provider Organization (EPO) rather than an HMO). Health plans, which must hold a commercial license, are selected through a competitive bidding process. Except in three more populated counties (Dade, Broward, and Palm Beach), where two or more HMOs participate, there is only one participating HMO per county and, therefore, enrollees in most counties do not have a choice among plans. At the time of the site visit, 15 health plans were participating in *Healthy Kids*. No plan operates in every county and most operate in only a small number of counties. State officials indicated that plan participation has changed since the program began due to withdrawals, additions and mergers. Figures provided by the state indicate that, since December 1998 there have been 24 instances of a plan withdrawing from one or more counties, and 27 instances of a plan either being added or expanding into new service areas (much of this was associated with the program's expansion into additional counties).

In counties with more than one participating HMO, children are assigned automatically to a plan but are given the option of switching plans as long as they do so within 30 days. After the initial 30-day period, enrollees are locked in for the remainder of the year (they may switch plans if their primary care provider no longer participates in their selected plan). Health plans may either assign an enrollee to a primary care provider or have enrollees select one. In either case, enrollees may switch their primary care provider at any time. The two health plans we interviewed indicated that most often the primary care provider is assigned automatically by the plan. *Healthy Kids* program officials reported that closed panels are not uncommon within health plan provider networks, and that this is an important consideration in selection and renewal of health plan contracts.

- The ***MediKids*** delivery system utilizes Medicaid providers and HMOs and makes enrollment in an HMO mandatory in counties with more than two participating HMOs. Otherwise, enrollees can opt to participate in the PCCM program and services are billed directly to the state and reimbursed on a fee-for-service basis. As of late September 2001, 13 health plans participated in Medicaid and *MediKids*. Of Florida's 67 counties, 23 had one or two participating HMOs, 13 had more than two, and 31 had no health plans participating in Medicaid/*MediKids*. New enrollees may access counseling about plan and provider choices through a special telephone

hotline. If new enrollees do not select a provider, they are assigned automatically to one by *MediKids* staff. State officials explained that this is done to ensure children can begin accessing care as soon as possible, but that enrollees are allowed to switch their managed care provider at any time during the year.

- ***CMS and BHSCN.*** The *CMS* program and its behavioral health subcomponent both place a heavy emphasis on care coordination and organized provider networks, with the programs themselves serving as the managed care entity. Because the provider networks were largely in place when *KidCare* took effect, the biggest change for *CMS* is that under *KidCare* it was given financial responsibility for managing the care of Title XXI enrollees. *CMS* contracts with the state and subcontracts with BHSCN, and is paid by the state on a capitated basis. The programs contract with providers to serve in their networks, and in most cases providers are reimbursed on a fee-for-service basis. Children are linked with a primary care provider, who may be a specialist. The BHSCN contracts with lead agencies in each county or service region (typically community mental health agencies). For children enrolled in the BHSCN, primary and acute care services are managed by *CMS*.

For children covered under Title XIX, families may choose whether to enroll their child in the *CMS* network or enroll in the PCCM program, and roughly 75 percent of families opt for PCCM. Children covered under Title XXI, however, must be enrolled in the *CMS* network. *CMS* also operates a safety net program that provides wrap-around coverage for services excluded from benefit packages under *KidCare* and private insurance plans. Services covered under the safety net program typically include such things as specialty medical care, pharmaceuticals, home health care, and durable medical equipment. The safety net program also covers children during periods of transition into and between different programs.

- ***Medicaid.*** Medicaid enrollees have a choice of enrolling in an HMO or in the PCCM program in counties where an HMO participates with Medicaid. Thirteen plans participated as of September 2001 and 36 counties had at least one participating HMO. State officials noted that most of these plans are “Medicaid focused” and regional. Medicaid participants are counseled about their choices, both plans and providers, by a third party entity. In counties without a Medicaid HMO, the PCCM program is the only option. Between 60 and 70 percent of Medicaid enrollees are in the PCCM program.

There is some overlap between the plans participating in *Healthy Kids* and Medicaid/*MediKids*, but most plans participate in one program or the other. As of September 2001 for Medicaid and November 2001 for *Healthy Kids*, five health plans participated in both programs (out of 13 Medicaid and 15 *Healthy Kids* plans). State officials indicated that the provider networks for *Healthy Kids* and Medicaid health plans overlap considerably. State

program and local health plan officials indicated that many families moving between *Healthy Kids* and Medicaid, therefore, are able to keep the same physicians.

Dental care under *Healthy Kids* is currently managed by one of three specialized dental managed care entities. In counties where dental coverage is available, enrollees are assigned to one of the three dental plans, then given 30 days to switch to another plan before being locked in for the remainder of the year.¹⁴ (Because dental coverage is not optional for families, they do not pay an additional premium for this coverage.) Dental care under the other *KidCare* components (Medicaid, *MediKids*, and *CMS*) is provided through traditional fee-for-service arrangements. Medicaid and *MediKids* use only dentists who have agreed to participate in Medicaid and accept the Medicaid fee schedule. *CMS* is not limited to contracting with Medicaid dental providers for the Title XXI population, but they are required to use the Medicaid fee schedule. In the past, *CMS* was allowed to pay higher rates for both dental and medical care if necessary to secure adequate participation among providers.

Behavioral health care services are included in the benefit package under contracts with *Healthy Kids* health plans. We were told that some *Healthy Kids* health plans subcontract with specialized behavioral health organizations, but that most manage this care directly. There are no special behavioral health care arrangements employed under Medicaid and *MediKids*. Under *CMS*, mental health and substance abuse services for individuals with more serious problems are managed by the BHSCN, with other services managed directly by *CMS*.

In Florida's many rural counties, *Healthy Kids* is the only *KidCare* program that uses risk-based managed care arrangements. The *KidCare* legislation authorizes establishment of an

¹⁴As mentioned earlier, dental coverage is being phased in gradually and is expected to be available in every county by late 2002.

Exclusive Provider Organization, or EPO, in rural areas under *Healthy Kids*. A single entity licensed as a commercial carrier (Clarendon) holds contracts with FHKC to operate an EPO. It subcontracts with other entities for development of the provider network, case management and utilization review, and pharmacy benefit management. Enrollees must use network providers and are encouraged to establish a usual source of care. There are no prior authorization requirements—enrollees may self-refer to any provider in the network. *Healthy Kids* enrollment in this EPO was roughly 22,000 at the time of the site visit, a volume that the insurer characterized as manageable. (The rural EPO the carrier operates in Texas under SCHIP grew quickly to over 140,000 enrollees, which led to difficulties securing enough providers.)

C. PAYMENT ARRANGEMENTS

Payment rates for both plans and providers are similar or identical to Medicaid rates for all *KidCare* program components except *Healthy Kids*. Under Medicaid, *MediKids*, and *CMS*, capitation payments to plans are based on Medicaid cost and utilization patterns for the prior two years. Separate rates are calculated for different ages, eligibility groups, and regions. Capitation amounts are set at 92 percent of projected costs. In turn, health plans (and *CMS*) are required to pay providers using the Medicaid fee schedule. Initially, the per-member-per-month amount paid to *CMS* for Title XXI enrollees was based on historic costs for the Medicaid SSI population. Subsequently, the rates were lowered when it became clear that children enrolling under Title XXI tended to have less intensive problems and service use patterns than a typical SSI recipient. (*CMS* officials reported that the initial pool of Title XXI enrollees was more likely to contain children with conditions like Attention Deficit and Hyperactivity Disorder (ADHD) and asthma.) Recently, however, *CMS* has experienced an increase in the number of children enrolled with more serious conditions, which state officials attribute to growing awareness of the program among Title XXI-eligible families.

Under *Healthy Kids*, health plan capitation payments are tied loosely to Medicaid rates, but the program is permitted to increase rates to reflect data on actual cost. Rates paid to health plans under *Healthy Kids* are based on bids submitted by the plans and subsequent negotiations with the FHKC. Plans negotiate one rate for children of all ages. The three health plans interviewed during the site visit indicated that they look at Medicaid utilization and cost data when they calculate their bids under *Healthy Kids*, but that they also take into account cost and utilization data within the given market area.

Key informants reported that *Healthy Kids* health plans typically base provider payments on the Medicaid fee schedule, but that they sometimes pay higher rates in order to secure adequate provider participation in some regions or for some types of services. Specific payment arrangements are negotiated between the plans and the providers and can vary greatly across plans and geographic areas. *Healthy Kids* program officials reported that most plans pay providers using a combination of capitation and fee-for-service arrangements. As mentioned earlier, *CMS* is no longer permitted to pay rates that are higher than the Medicaid fee schedule.

For dental care, there is a more substantial difference in the rates paid to Medicaid and *Healthy Kids* plans. Under Medicaid, health plans receive roughly \$10 per member per month while the dental plans under *Healthy Kids* receive twice that amount, \$20 per member per month. On the provider side, dental health plan officials we interviewed indicated that arrangements with providers vary considerably across providers and regions. Plan officials noted that often dentists want to be paid on a fee-for-service basis, and that many are willing to accept deeply discounted fees but they do not like capitated arrangements. Plans are more likely to be able to negotiate full or partial capitation with providers in more populated areas.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

State program officials, advocates, and plan and provider representatives indicated that access to primary care is adequate and fairly comparable across the various *KidCare* components, including Medicaid. Surveys conducted by ICHP confirm that access to routine primary care is good among *KidCare* enrollees, and that *KidCare* enrollment is associated with a significant decline in unmet needs for most types of services (Shenkman and Bono 2003). Other notable findings from the ICHP baseline and follow-up enrollee surveys include improved compliance with recommended immunization schedules in *KidCare* programs serving younger children, an increase in the proportion of *KidCare* enrollees with a usual source of care, and high levels of satisfaction with *KidCare* providers across all program components.

When asked to describe any access problems, key informants noted two areas of concern: dental and specialty care, especially in rural areas. Providers in the rural Okeechobee region raised concerns about the adequacy of the *Healthy Kids* provider network. They noted that the entity responsible for the *Healthy Kids* EPO is relatively new to the market and may not understand that on top of overall shortages, many providers in rural areas don't serve children. Provider participation problems, they added, are greatest with certain specialty services—dermatology, orthopedic, and pediatric psychiatric services. Okeechobee providers reported that no orthopedic providers are willing to serve *KidCare* enrollees, so families must travel 60 to 70 miles to access these services. Mental health is another area where we heard that the need for services is great and there are not enough providers serving Medicaid and uninsured populations. Securing adequate access to specialty care, informants added, is a struggle in many areas, and the situation is somewhat worse under Medicaid than under *Healthy Kids*. ICHP's new enrollee survey found that among enrollees who needed specialty care during the year, the percentage

reporting that doing so was “not a problem” was over 70 for each of the *KidCare* components (Shenkman and Bono 2003).

Low payments are only part of the reason specialists do not participate in Medicaid, informants noted. Other factors include dislike of managed care and the perception that the Medicaid population is more difficult to work with. Health plan informants also noted that it is sometimes easier to get specialists to participate in a program focused only on children because physicians have a harder time saying no to this population.

Many informants indicated that dental care access is problematic throughout the state, particularly for the uninsured and those covered by Medicaid. In some areas, access problems stem largely from a shortage of dentists. In addition to this, key informants reported that many dentists resist participating in managed care. An official from one of the dental managed care plans explained that this resistance to managed care is sometimes because of the payment arrangements (resistance to capitation-based financing), but more often it is due to administrative obstacles. This plan has found, for example, that they can persuade many dental providers to participate by assuring them that payment will be made in a timely manner, that their calls will be answered promptly, and that their questions will be addressed adequately.

Shortages of dentists willing to participate under Medicaid are especially acute, key informants noted, in part because payment is low (rates are 15 to 20 percent of Medicare rates), but also because providers say that dealing with the program involves too many hassles and the population is noncompliant and otherwise difficult to work with. Demand (or at least the need) for dental care is also very high in some areas. Providers in Okeechobee were anxiously awaiting introduction of the dental benefit under *Healthy Kids*, as the need for dental care is great among families in their area and the FQHC in Okeechobee was the only dental provider serving *KidCare* enrollees and the uninsured. ICHP’s enrollee survey found that many *KidCare*

enrollees continue to have unmet dental care needs 12 months after enrollment. The latest survey was conducted prior to the roll-out of the comprehensive dental benefit under *Healthy Kids*, and program officials hoped the new benefit would reduce unmet needs under that program (which actually increased over time according to the enrollee survey).

Families involved in more than one of the various *KidCare* programs may face different delivery system features. It is possible, for example, for one Title XXI-eligible family to have children enrolled in Medicaid (an infant), *MediKids* (children under age 5), *Healthy Kids* (children between the ages of 5 and 19), and/or *CMS* (children of any age with special health care needs). Families with children in more than one program component may have different health plan choices and potentially different provider networks. State program officials we interviewed had differing views on the extent to which this poses problems for families. One official reported that families almost always have access to the same providers even if the health plan choices are different. Other officials reported that provider choices do differ from one component to another, especially in some areas of the state.

As expected, the state has been able to keep the amounts it pays to plans under *Healthy Kids* reasonable and stable because the population covered under *Healthy Kids* excludes children with special health care needs. *Healthy Kids* health plans have a strong financial incentive to ensure that children with more intensive needs are identified and transferred to *CMS*. The health plans we met with indicated that capitation payments under *Healthy Kids* were adequate. Most children enrolled in *Healthy Kids* are indeed healthy, and utilization is reportedly fairly low and predictable.

Differing benefit packages and covered populations make it difficult to compare plan payment rates under the various *KidCare* components. A general sense for rate differences across the components can be gleaned from the per-member-per-month capitation payments

allocated for each *KidCare* component in Florida's SFY 2000 budget. The budgeted amounts averaged \$75 for *Healthy Kids* (this did not include dental); \$85.27 for adolescents in the Medicaid expansion; \$89.98 for *MediKids*; \$730.90 for the *CMS Network*; and \$1,441.67 for the BHSCN.

One of the health plans we interviewed contracts with both Medicaid and *Healthy Kids*. Plan staff indicated that the rates they receive are roughly comparable after adjusting for differing utilization patterns. Several informants also noted that while Medicaid rates appear lower than rates paid under *Healthy Kids* when adjusted for a comparable cohort of children, utilization under Medicaid tends to be somewhat lower than under *Healthy Kids*. One state official suggested that utilization may be lower for some children because of problems with access or problems maintaining coverage continuously under Medicaid.

Provider payment has the potential to be higher under *Healthy Kids* than the other *KidCare* components, but key informants reported that most often *Healthy Kids* providers are paid rates that are comparable to Medicaid. Rates paid to providers under *MediKids* and *CMS* are required to follow Medicaid fee schedules. Staff we interviewed at one of the health plans reported that, historically, they have paid providers higher rates for *Healthy Kids* than for Medicaid, but that this is changing in more recent contract negotiations. As the payments the plan receives from FHKC begin to move closer to Medicaid premium rates, the plan is trying to negotiate provider payments that are more in line with Medicaid levels.

Providers we met with reported varied experiences with Medicaid and *Healthy Kids* health plans. Some plans, they noted, are easier to work with than others, and are viewed as having higher quality standards. While we were able to meet with only a small number of providers, most of them indicated that they do not contract with every *KidCare* health plan. This suggests that there would be some disruption for families moving from one plan to another. Providers

also noted that children are sometimes assigned to a different plan and/or primary care provider when they are reenrolled after a black-out period for nonpayment of premiums.

Medicaid fee-for-service rates in Florida are among the lowest in the country, state officials noted. The legislature passed rate increases for physicians during the last two legislative sessions, but at the time of the site visit a four percent increase in physician rates slated to take effect in state fiscal year 2001-2002 was expected to be reduced to a one percent decrease in light of the state's budget crisis. The special budget session was also expected to result in reductions in management fees under the MediPass PCCM program, from \$3 to \$2 per member per month. Providers we met with indicated that payment under the MediPass PCCM program is higher than Medicaid HMO plan payments. Declining Medicaid fees, and greater reliance on Medicaid fees as the basis for provider payment under managed care, could increase Florida providers' resistance to participating in managed care in the future. Several informants noted that Medicaid provider fees barely cover costs for basic primary care and are far below cost for many specialty services.

VIII. COST SHARING

A. POLICY DEVELOPMENT

Cost sharing was an integral component of the *Healthy Kids* program prior to passage of Title XXI legislation, and Florida chose to maintain it in its separate child health program components. Consistent with Title XIX requirements, there is no cost sharing imposed under the Medicaid expansion component of Florida's SCHIP program. The Florida legislature's decision to include cost sharing in *Healthy Kids* stemmed primarily from (1) the desire to model private health insurance market for families who may transition into it from *KidCare*; (2) an interest in minimizing any welfare stigma by making *KidCare* look more like private insurance; (3) a belief that families would place a higher value on the coverage if they contributed something to the cost; and (4) an interest in generating revenue to help finance the program.

To comply with the Title XXI requirement that cost sharing not exceed five percent of the family's income, the state modified previous cost sharing provisions for *Healthy Kids*. Premiums were adjusted from \$10 per child per month to a flat monthly amount of \$15 per family (regardless of the number of children), and copayments for most services were reduced from \$5 to \$3.

B. PROGRAM CHARACTERISTICS

As presented in Table VIII.1, the three separate child health program components of Florida *KidCare* (*MediKids*, *Healthy Kids*, and *CMS*) charge a premium of \$15 per family per month. Copayments for certain services (see Table VIII.1) are required for children enrolled in *Healthy Kids*, but there are no copayment requirements under the *MediKids* and *CMS* components. As dental coverage is introduced under *Healthy Kids*, no additional premiums are imposed and there are no copayments for dental care.

TABLE VIII.1
COST-SHARING POLICIES

Policy	Medicaid Expansion	<i>MediKids</i>	<i>Healthy Kids</i>	<i>Children's Medical Services Network</i>
Enrollment Fee	No	No	No	No
Premiums	No	\$15 per family, per month	\$15 per family, per month ^a	\$15 per family, per month
Co-payments	No	No	\$3.00 per professional visit or prescription \$10.00 for eyeglasses and inappropriate use of emergency room or emergency transportation.	No
Penalty for premium nonpayment	No	Disenrollment and ineligibility for reinstatement for 60 days.	Disenrollment and ineligibility for reinstatement for 60 days.	Disenrollment and ineligibility for reinstatement for 60 days.
Penalty for co- payment nonpayment	No	No	No	No
Deductibles	No	No	No	No

SOURCE: State of Florida. *Florida KidCare Program: Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Health Care Financing Administration*. July 2000.

^aThe monthly premium may be less at a county's option. Children in families with incomes above 200 percent of FPL are not eligible for Title XXI in Florida. However, these children may participate in Florida *KidCare* without premium assistance (that is, they must pay the full premium cost of the program).

FPL = federal poverty level.

Under *Healthy Kids*, families with incomes over 200 percent of FPL may enroll their children by paying the full unsubsidized premium, the amount of which varies across counties. (As of early November 2001, the unsubsidized monthly premium amounts ranged across counties from a low of \$68 to a high of \$133 for medical, and from \$88 to \$153 inclusive of dental.) Premiums are due at the beginning of each month, and families who fail to pay the premium within 30 days (by the last day of the month) are notified that their coverage has been cancelled. When enrollment is terminated for failure to pay the premium, families may not re-enroll their child(ren) for 60 days.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Most informants we met with indicated that they believed premiums and copayments under *KidCare* were affordable, and that families prefer to make a financial contribution to their child's health care. In addition, some informants mentioned that the premium component is beneficial because (1) families are more likely to use services when required to pay a premium; and (2) it allows for a passive redetermination process (although families may not have to submit redetermination paperwork, children will remain enrolled only if premiums are paid). *CMS* officials noted that it is appropriate that copayments are not imposed on *CMS* enrollees because this would amount to a substantial and unaffordable out-of-pocket contribution for most families.

These assertions are consistent with findings from ICHP's survey of disenrollees from the *Healthy Kids* program (Bono et al. 2000). This study found that only nine percent of *Healthy Kids* disenrollees left the program because they "...were dissatisfied with the amount of money that [they] paid every month for the health insurance policy," and that only one percent of *Healthy Kids* disenrollees left the program because of dissatisfaction with "...the amount of money that [they] paid at the time of the health care visit."

Many key informants expressed concern, however, about *KidCare*'s policy of terminating families who do not pay premiums on time. Some key informants indicated that many families want to pay but are disenrolled because their payments are late. They added that the problem was much worse in the first couple of years, but that it this was still affecting a significant number of families. ICHP's evaluation reports are consistent with this and show that the situation has improved substantially over time. Results from the 1999 survey show that 56 and 35 percent of children who disenrolled from *Healthy Kids* and *MediKids*, respectively, did so due to premium nonpayment (Shenkman et al. 2001). This proportion decreased to 13 percent overall for children who disenrolled from these programs in 2002 (Shenkman and Bono 2003). In the survey of disenrollees conducted by ICHP, 49 percent of parents with disenrolled children reported that coverage had been cancelled due to premium nonpayment (Bono et al. 2000). Although some families may have intentionally stopped paying, others may have either forgotten to pay or missed the deadline. Several informants stressed that a grace period longer than 30 days is needed, as well as mechanisms other than the mail for families to make premium payments (for example, allowing families to pay in person at a local office or agency). For families who intend to pay but miss the deadline, the 60-day "blackout period" results in a lapse in insurance coverage for the child. On the other hand, some state officials believe that the premium nonpayment policy has encouraged families to take greater responsibility for making the payments on time. Since many private policies have similar requirements, they added, it is appropriate to have similar requirements for families of *KidCare* enrollees.

IX. FAMILY COVERAGE AND EMPLOYER SUBSIDIES

From the beginning, there was great interest in Florida in leveraging employment-based insurance for families with access to such plans. This type of approach appealed to the Governor and many legislators for the same reasons they favored the public-private partnership structure of *Healthy Kids*. In December 1998, the state submitted an amendment to the Centers for Medicare & Medicaid Services seeking approval for a premium assistance program. Under the amendment the state wanted the Centers for Medicare & Medicaid Services to grant an exception to the federal rule that employers contribute at least 60 percent of the premium cost. Because so many Florida businesses are small, and most do not offer employees dependent coverage, the state's proposed plan would have required smaller employers (those with fewer than 50 employees) to contribute 25 percent of the premium cost and the larger employers to contribute 50 percent. The proposal was debated at length but eventually rejected by the Centers for Medicare & Medicaid Services in November 1999. Key informants from the Florida legislature indicated that while there is still considerable interest in the idea of a premium assistance component, the current state budget crisis combined with high and growing enrollment numbers under existing *KidCare* components make it very unlikely that Florida will revisit the premium assistance program idea in the foreseeable future. For similar reasons, there has been virtually no consideration of expanding eligibility to parents under SCHIP.

X. FINANCING

Florida has the fourth largest SCHIP allotment in the country, at \$242 million for FFY 2000. Growing enrollment in *KidCare* has been reflected in a dramatic increase in expenditures, from \$6.4 million in FFY 1998 to \$174.5 million in FFY 2000 (Table X.1). By the end of the three-year period of availability, Florida had spent 86 percent of its FFY 1998 allotment of \$270 million. As mentioned earlier, key informants said that the state did not spend its full allotment because: (1) the allotment may have been based on an inflated estimate of the number of eligible children, (2) it took time for the program to become operational statewide, and (3) open enrollment periods (*MediKids*) and waiting lists in some counties (*Healthy Kids*) slowed enrollment.

Florida's enhanced federal matching rate for SCHIP was 69.57 percent and increased to 71.18 percent in October 2002. The state's 29 percent share of *KidCare* expenditures is funded with both the state and local funds. State funding comes primarily from the tobacco settlement trust fund, *KidCare* premiums, and general revenue appropriations. Local funding is generated through county-based "local match" contributions. Florida's state legislature has never funded the program fully. According to several informants, the Florida legislature tried to ensure that enrollment and expenditures under *KidCare* grew slowly, to ensure that state funds would be adequate to support the program when federal allotment amounts drop (during FFY 2002-2004). As one informant noted, "...now that health care costs are rising again, it will be interesting to see if we will in fact spend our full allotment in the coming years."

TABLE X.1

SCHIP ALLOTMENTS AND EXPENDITURES
(in millions, 1998-2000)

FFY	Federal Allotment	Expenditures	Expenditures as Percentage of Federal Allotment	Percentage of Year's Allotment Spent by End of FFY 2000	Redistributed Amount
1998	\$270.2	\$6.4	2%	86%	0%
1999	\$268.9	\$51.0	19%	0%	NA
2000	\$242.0	\$174.5	72%	0%	NA

SOURCE: *Federal Register Notice*, May 24, 2000; Kenney et al., "Three Years into SCHIP: What States Are and Are Not Spending." Urban Institute: September 2000.

SCHIP = State Children's Health Insurance Program
FFY = Federal Fiscal Year

At the time of the site visit, the state was projecting substantial budget shortfalls both for state fiscal year 2001-2002 and for subsequent years. The short falls were attributed to a general economic downturn following the incidents on September 11, 2001. Special sessions were convened to address the projected shortfalls. All departments were being asked to submit plans for reducing their budgets. As in many other states, Medicaid expenditures in Florida are a significant portion of state outlays each year and the significant growth in expenditures for that program since the onset of SCHIP had led some legislators to question the value of further outreach. An unexpected surplus in the *Healthy Kids* budget was expected to help carry that program through the current fiscal crisis but the outlook for the next fiscal year was uncertain. Political support for *Healthy Kids* remains strong, however.

Florida's local match component under *Healthy Kids* has become quite controversial since the onset of Title XXI. A brief overview of how the local match component has changed since

its inception is provided in Table X.2. The policy at the time of the site visit required counties with more than 500 *Healthy Kids* enrollees to contribute local matching funds ranging from 5 to 20 percent of the total premium cost, depending on when the county began offering *Healthy Kids*. Counties contributed a total of \$11.6 million in FY 2000-2001, 9.1 percent of total program funding for that year (FHKC 2001).

Counties participating in *Healthy Kids* prior to SCHIP agreed to the local match policies at a time when there were no federal funds available to finance the program. With the introduction of federal funds under Title XXI, *Health Kids* was expanded to additional counties and many, especially rural, counties struggled to meet their local match requirement. Further concerns arose about enrollment caps and waiting lists in counties that could not meet their local match, and inequities in the matching burden imposed on different counties. At the time of the site visit, the future of the local match component was being debated vigorously. Many were in favor of maintaining the local match component, perhaps with some modifications, because local involvement strengthens the program and makes the program more resilient fiscally, while others—at both the state and local level—felt strongly that the state should assume sole responsibility for funding the state’s share of the program.

Recent special session legislation suspended the local match requirement for state fiscal year 2001-2002, replacing these funds with the FHKC surplus (FHKC 2002).¹⁵ Furthermore, there is no local match requirement to fund Title XXI enrollment in state fiscal year 2002-2003, but non-Title XXI enrollment is funded with both state and local funds. Key informants noted that if the legislature made this cut permanent, FHKC would need to secure other funding or decrease *Healthy Kids* enrollment to compensate for the loss of local match funds.

¹⁵This special session legislation was signed by Governor Jeb Bush on December 17, 2001.

TABLE X.2

HISTORY OF LOCAL MATCH POLICY

Year	Policy
1992	<i>Healthy Kids</i> demonstration program launched in Volusia county. County agrees to assume responsibility for the federal portion of program costs if it wishes to continue the program after the 3-year demonstration funding expires.
1993	Florida Healthy Kids Corporation Board would negotiate a local match schedule individually with each county participating in <i>Healthy Kids</i> , and counties would contribute a minimum of five percent of the total local premium cost, which would increase annually.
1996	Florida Healthy Kids Corporation Board revised the local match schedule – counties contribute five percent the first year in which the <i>Healthy Kids</i> program was implemented, which would increase the county contribution in a stepped fashion over a 5-year period until reaching a maximum of 40 percent. Rural counties had the option of forming groups of four or more and taking 8 years to reach the 40 percent match rate.
1998	In response to Title XXI legislation, the maximum local match rate decreased from 40 to 20 percent. Counties would begin at a five percent minimum match rate, which would increase by annual increments of five percentage-points until they reached the 20 percent maximum. The Florida Legislature required all counties to offer the <i>Healthy Kids</i> program, even in the absence of matching funds and gave each county 500 free <i>Healthy Kids</i> enrollment slots, beyond which the county was required to provide local matching funds. To comply with federal law, restrictions were introduced on the allowable sources of local matching funds (e.g., funds could no longer be raised through contributions from health care providers).
1999	Local match levels are frozen by the Florida legislature for all counties, leaving 36 counties contributing 0 percent, 11 counties contributing 20 percent, and the remaining counties in between.
2000	Dental benefit package made available in counties contributing (or committing to contribute) at least \$4,000 in matching funds.
2001	Special Session Legislation annuls the local match requirement for state fiscal year 2001-2002—the existing FHKC surplus will be used to replace these funds.
2002	Legislature chose not to require local match to fund Title XXI enrollment.

SOURCE: Medimetrix Consulting. Florida Healthy Kids Local Match Policy Assessment: Final Submission to the Florida Legislature. Cleveland, OH. November 30, 2000.

Florida Healthy Kids Corporation (FHKC). “State Legislative Update: Updated as of January 15, 2002.” Tallahassee, FL: 2002.

The state contracted with Medimetrix Consulting (2000) to assess the local match component policy. Their final report, among other things, reviews the history of the local match and outlines its key advantages and disadvantages (based on interviews with a variety of state and local informants and a review of the literature on other local match programs). Findings from this assessment, and the views of key informants from the site visit, suggest that the primary advantages of the local match include:

- ***Community Buy-in.*** A local match component ensures greater commitment from the community by shoring up financial and political support that will help insulate the program from potential state-level budget cuts. Furthermore, communities that make a financial investment in the program are more likely to involve themselves in program implementation, thus promoting its success and demonstrating the county's commitment to its children.
- ***Funding.*** In times of state-level fiscal difficulties, additional local dollars help maximize available federal funds and the number of children that are covered. In addition, local providers benefit from the additional federal and state funds that the local contribution makes available. The infusion of federal and state funds into the local economy also benefits local providers.
- ***Coverage of Title XXI-Ineligible Children.*** Implementation of Title XXI in Florida meant that some children who had previously been eligible for *Healthy Kids* were no longer eligible.¹⁶ Children ineligible for Title XXI are currently unable to enroll in *Healthy Kids* unless the county supplies the total premium cost not covered by the family. Local matching funds make coverage of these children possible.

Disadvantages or problems raised about the local match component in Florida include:

- ***Barrier to Enrollment.*** Some children may be unable to obtain coverage because they live in a county that is either unwilling or unable to provide the funding. The Title XXI legislation renders the task of raising local money more challenging by limiting the allowable sources of these funds. Some counties cannot fund *Healthy*

¹⁶The following are examples of children who would be Title XXI-ineligible but who would have previously been eligible for Healthy Kids: (1) a child who is an alien, but who does not meet the definition of qualified alien, in the United States; and (2) a child who is a dependent of a state employee.

Kids, and those that do spend less on other programs. Many are concerned about children in these areas. This issue is particularly acute in rural areas.

- ***Inequitable Local Match Levels.*** In state fiscal year 2000-2001, the Florida legislature froze local match percentages at their state fiscal year 1999-2000 levels (Medimetrix 2000). Because each county's percentage contribution increases over time, counties that had participated in *Healthy Kids* for several years had their local match percentage frozen at a substantially higher level than counties that had just started participating. Moreover, some counties contend that inequities result from enrollment caps that are based on the amount of local money raised rather than a county's need.

XI. CONCLUSIONS AND LESSONS LEARNED

Florida's SCHIP approach is innovative in its use of existing programs and infrastructure while also promoting a new, integrated identity for publicly-funded coverage for children. New and preexisting child health coverage were combined together with traditional Medicaid for children under a new umbrella program identity, *KidCare*. Through *KidCare*, Medicaid and SCHIP are promoted as one program and they use a common application. However, some are concerned that the process of making decisions about *KidCare* is too cumbersome due to the absence of a single agency to lead it. Lessons from Florida's experience with this unique program structure are highlighted below.

- Florida seems to have succeeded in making application to the multi-component *KidCare* fairly seamless for families through the use of a common application form and centralized application processing. Although some families continue to identify with a particular program component (such as Medicaid, *Healthy Kids*, or *CMS*), the same simplified *KidCare* application form is used to establish eligibility for each *KidCare* component. In streamlining the application, program partners agreed to eliminate any verification, asset test, and face-to-face interview requirements across all *KidCare* program components. The simplification and streamlining initiated because of SCHIP led to significant "spillover" benefits for Medicaid.
- While the state got started quickly by building on existing infrastructures from the state's pre-SCHIP *Healthy Kids* initiative, accommodating *KidCare*'s larger scale and scope required refinements in the outreach approach and in the systems supporting application and enrollment processes. The state learned that staggered media campaigns focused on particular media markets are more effective than simultaneous statewide campaigns. To handle the large increase in applications and related inquiries, the state expanded and improved its telephone hotline and application processing systems. By all accounts, these systems have improved greatly over time, and although key informants noted further needed improvements, especially with the hotlines, recent evidence indicates that families' experience with the hotlines has improved substantially.
- The application and enrollment process is predominantly mail-based and quite centralized, which reportedly works very well for many families, although others would benefit from local assistance. Florida's program does not include a formal community-based application and enrollment assistance component. While local outreach workers are able to assist some families, key informants at the local level

wished there was more support for application assistance. Some families, especially those with language and/or immigration issues, need help completing the application and/or understanding documents and enrollment materials distributed during the process.

- Florida's SCHIP enrollment has grown steadily and is currently among the highest in the country, but growth was slow initially and has not yet met the enrollment target used to establish the state's allotment. It took time to expand *Healthy Kids* statewide and to develop and implement the new *MediKids* component for younger children. Many key informants also noted that the target population estimates used to generate the state's allotment overestimated the number of eligible children because they included many recent immigrants who are ineligible under SCHIP.
- The increase in Medicaid enrollment has exceeded expectations and has some worried that this may lead to cuts in funding for *KidCare* outreach. Since SCHIP was launched in Spring 1998, Medicaid enrollment for children has increased by more than 400,000, bringing total enrollment to over 1.1 million. Several informants noted that this large increase in the Medicaid entitlement program may lead state lawmakers to push for cuts in *KidCare* outreach funding (to limit further increases).
- While Medicaid and SCHIP enrollment processes are highly coordinated, redetermination processes differ considerably. Medicaid redetermination requires families to complete another application form and participate in a face-to-face interview. For other *KidCare* components, redetermination is passive; families are mailed a form containing application information and asked to respond only if that information has changed. Although Medicaid cannot utilize passive enrollment because it does not impose premiums, key informants noted that the process could be more family friendly and more attuned to ensuring continuous coverage.
- The passive redetermination approach utilized for *KidCare*'s non-Medicaid components has resulted in high retention rates. This approach has virtually eliminated terminations related to paperwork concerns. A new call center implemented by *Healthy Kids* also promises to increase retention rates. Families are called soon after enrolling in the program, and again on their child's birthday. The calls provide an opportunity to orient families to the program and address any questions or concerns. An evaluation of this new component found that it had a significant impact on retention rates as well as satisfaction levels.
- Service delivery systems vary considerably across the different *KidCare* components, and while the evidence is limited it appears that access for many services is similar and good under Medicaid and SCHIP, though somewhat better under SCHIP for some services. Managed care is used more extensively in SCHIP than in Medicaid. Access to primary care was considered generally adequate and comparable across *KidCare* components, though provider reimbursement rates are considered poor for both primary and specialty care. Many worry that provider participation, and in turn access, will diminish unless reimbursement rates increase. Access to specialty care was viewed as a problem in some rural areas under both Medicaid and SCHIP; access to mental health services was described as a concern in both rural and urban areas, and worse under Medicaid. Participation of dentists and access to dental care was

considered better under *Healthy Kids* than the other program components because payment rates are higher and more timely through the *Healthy Kids* managed dental care program.

- By all accounts, cost-sharing levels under *KidCare* are considered reasonable and appropriate, but some consider the consequences of late payments to be too punitive. Premiums of \$15 per family are due each month, and enrollment is terminated for 60 days if payments are not received by the end of the month. Nearly half of those who lose SCHIP eligibility do so because of failure to pay premiums on time.
- Although the benefit package for children enrolled in *Healthy Kids* is not as comprehensive as the Medicaid package, it is considered adequate because children enrolled in *Healthy Kids* are typically healthy. Children covered under the other *KidCare* program components receive either the Medicaid benefit package or, in the case of the *CMS* Network, an enhanced Medicaid package that includes additional support services. Because children with special health care needs are not included in the *Healthy Kids* program (they are enrolled in the *CMS* network), the more limited *Healthy Kids* benefit package is considered adequate for most enrollees.
- Crowd out was not a major concern during the design phase for SCHIP and no waiting periods are imposed under any *KidCare* components. The consensus among state lawmakers and others is that few lower-income families have access to employer-sponsored policies, and that available options are very expensive. Studies conducted by Florida's evaluation contractor suggest that some families (perhaps as many as 10 to 30 percent) enrolling in SCHIP have access to employer-sponsored insurance but that those options are considered too costly (on average, 8 percent of family income).
- Financial concerns had started to surface at the time of the site visit and were expected to worsen as the state grapples with major budget shortfalls. Florida's budget problems stem from both the general downturn in the economy combined with tourism industry losses tied to events on September 11, 2001. It is unclear how statewide budget cuts will eventually affect *KidCare*. Adding to the financial concerns is the possibility that Florida's local match program will be eliminated—the local match requirement to cover Title XXI-eligible children was waived for state fiscal years 2001-2002 and 2002-2003. Local match payments have contributed roughly 10 percent of the state's share of *Healthy Kids* expenditures.

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APPENDIX A

KEY INFORMANTS

KEY INFORMANTS

Organization	Name	Title
Tallahassee, Florida		
Agency for Health Care Administration	Gary Clarke	Former Medicaid Director
	Peggy Comer	Contract Manager, Helpline for <i>MediKids</i> Choice Counseling
	Dennis Eskew Paula McAuley	<i>MediKids</i> Health Care Program Analyst Supervisor, Recipient File Management Unit
Department of Children and Families	Joyce Raichelson	<i>MediKids</i> Program Administrator
	Nancy Ross	Administrator/Researcher
	Alan Strowd	Bureau Chief, Medicaid Contract Management
Florida Department of Health	Linda Ginn	Senior Management Analyst Supervisor
	Michael Sorrell	Medical/Health Care Program Analyst, Behavioral Health Network
	Patrick Williams	Medical/Health Care Program Analyst, Behavioral Health Network
Florida Department of Health	Jody Blalock	<i>KidCare</i> Outreach Coordinator
	Margaret Dunaway	Contract Manager
	Phyllis Sloyer	Director, <i>CMS</i> Network and Related Programs
Florida Healthy Kids Corporation	Rose Naff	Executive Director
Florida <i>KidCare</i> Coordinating Council	Rick Bucciarelli, M.D.	College of Medicine, University of Florida, President, Florida Pediatric Society
	Linda Merrill	Florida Child Health Coalition
	Phyllis Sloyer	Florida Department of Health, Director of the <i>CMS</i> Network and Related Programs
	Julia R. St. Petery Louis St. Petery, Jr., M.D.	Practicing Pediatrician, Tallahassee, FL Executive Vice-President, Florida Pediatric Society; Florida Healthy Kids Board Member
Florida Legislature	Connie Wells	State Coordinator for Family Voices
	Karen Woodall	National Association of Social Workers
	Mike Hansen	Policy Coordinator, Office of Policy and Budget, Florida Health and Human Services
Florida Legislature	Phil Williams	Staff Director, Committee on Health Promotion
	John Wilson	Staff Director, Florida Senate Committee on Health, Aging, and Long-term Care

Organization	Name	Title
The Lawton and Rhea Chiles Center	Gail Vail	Program Director, Florida <i>KidCare</i> Interagency Collaboration Project
	Betty Serow	Program Director, Florida <i>KidCare</i> Interagency Collaboration Project
Broward County, Florida		
Broward County Health Department	Renee Cundiff	Broward County <i>KidCare</i> Outreach Coordinator
Broward County School Board	Marcia Bynoe	Director, Health Education Services
Children's Medical Services Network	Mary Hooshmand, RN, MS	Nursing Director
Joe Dimaggio Children's Hospital	Palghat Alamelu, M.D.	Director, Division of Pediatrics
North Broward Hospital District	Pauline Grant, MS, MBA, CHE	Vice President, Ambulatory Services
	Anna Hernandez	Pediatrician
	Dona Nichols-Jones	Project Director, Business Development
Pediatric Associates	Phil Levine, M.D.	Pediatrician
South Florida Pediatric Surgeons, P.A.	Eric J. Stelnicki, M.D.	Pediatrician
Vista Health Plan	Kathy Brooks	Manager, Quality Management
	Rosa Cozad	Vice President of Commercial and Government Programs Marketing
	Barbara Ceuleers	Vice President, Provider Relations
	Robin Connor	Manager, Care Management
	Karla Reyes	Supervisor, Provider Relations
Okeechobee County, Florida		
Department of Children and Families	Yvette Kutner	<i>KidCare</i> Coordinator
	Kara Rheame	Program Administrator
Florida Community Health Centers, Inc.	Edwin Brown	CEO
	Christopher Robshaw, M.D.	Vice President of Clinical Operations
Hendry County Health Department	Pam Fisher	<i>KidCare</i> Regional Outreach Coordinator
Okeechobee County Health Department	Connie Thacker	Director of Nursing
Okeechobee County School Board	Cynthia Davis	Shared Services Facilitator
	Zella Kirk	Assistant Superintendent

APPENDIX B

APPLICATION

SECTION 3. Household information

- 1 If you are applying for an unborn child, what is the expected due date? (MM/DD/Year)
- 2 Number of adults living in your household Number of children: Total
- 3 If anyone in your household pays child support, write in the monthly amount: \$ _____
Name of person who pays it: _____
(Your answers may determine deductions and may qualify your child for lower cost coverage.)
- 4 Do your children have unpaid medical bills from the last three months? Yes No
- 5 Is any child in your household a refugee or asylee? Yes No If yes, how many? _____
- 6 In what language do you prefer to receive mail?
 English Spanish Haitian Creole
- 7 Where did you hear about Florida KidCare?
 School Friend/Family TV/Radio Newspaper
 Health Care Provider Other: _____

SECTION 4. Monthly income worksheet

List all income received by parents and children listed on this application. Do not list income for anyone outside of this household. Be sure to show the amount of income before taxes and other deductions. Use an extra sheet if needed.

(Write in the MONTHLY amount for each kind of income.)

Name (First and Last)	Is this person in school full time? (Yes or No)	Monthly Income from Work	Monthly Child Support	Monthly Social Security	Monthly SSI	Monthly Workers' Comp, Retirement, Unemployment, other	MONTHLY TOTALS (add up for each name)

SECTION 5. Day care

List the payments made for day care for a child (or adult with disabilities) so that someone in your household can work. Your answers may determine deductions from the Total Monthly income figure and may qualify your child for lower cost coverage.

Monthly Amount of Day Care Payment for Each Person in Day Care	Name of Person in Care	Under age 2? Yes/No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6. Monthly premiums and attachments

There is no cost for Medicaid for children (KidCare Medicaid). There is a minimum \$15 monthly premium for MedKIDS, Healthy Kids, and the Children's Medical Services Network. We suggest you send one check or money order for \$15 to avoid delaying your child's (or children's) first month of coverage. If you need to pay more than the minimum we will let you know. PLEASE DO NOT SEND CASH. If your child (or children) is approved for Medicaid or denied coverage, the \$15 will be refunded.

ARE YOU ATTACHING (please check Yes or No) . . .

A check or money order for \$15 made payable to Florida KidCare?

For each non-citizen applicant child, a copy of that child's immigration documents?

For American Indian/Alaska Native children, a copy of the child's Tribal I.D. card or other documents?

- Yes No
 Yes No
 Yes No

Mail to:
Florida KidCare
P.O. Box 980
Tallahassee, FL 32302-0980

SECTION 7. Certification and authorization

- I certify that the information provided on this application is true and correct to the best of my knowledge.
- I understand that the information will be kept confidential in accordance with Florida and federal law.
- I understand the information I have provided in this application will not be shared with the Immigration and Naturalization Service (INS).
- I understand the information I provide will be verified, which may include computer file matching and that I may be requested to provide other information.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for research.
- I have read and understand my rights and responsibilities as they apply to the Medicaid program.
- I understand that the Florida KidCare program does not discriminate because of race, color, sex, age, disability, religion, nationality or political belief.

Signature Required _____

DATE: _____



Florida KidCare

Questions? Call 1-888-540-5437. This is a free call.
www.floridakidcare.org
(TTY 1-877-316-8748)

Good news for Florida's families!

Through Florida KidCare, the State of Florida offers health insurance for children from birth through age 18, even if one or both parents are working. It includes four different parts, or programs. When you apply for the insurance, Florida KidCare will check which program your child may be eligible for based on age and family income:

- **MediKids:** for uninsured children ages 1 through 4.
- **Healthy Kids:** for uninsured children ages 5 through 18.
- **Children's Medical Services Network:** for uninsured children birth through 18 who have special health needs or ongoing medical conditions.
- **Medicaid:** for children birth through 18. A child who has other health insurance may also qualify for Medicaid.

What services are covered?

Here are some of the services Florida KidCare covers:

doctor visits	surgery	vision & hearing
check-ups & shots	prescriptions	dental
hospital	emergencies	mental health

Who will provide my child's care?

All Florida KidCare programs use selected doctors, dentists, hospitals, therapists, or health plans to provide services. In some areas of Florida, you may be able to choose from more than one health plan.

How do I apply? Instructions

Using blue or black ink, fill out this simple application form and mail it as soon as possible. Some Florida KidCare programs may have limited space. Applications are accepted on a first-come, first-served basis. Follow the directions on the application form and please print your answers. Here is some more information to help you with the application.



SECTION 1. PARENT (OR GUARDIAN) INFORMATION.

Parent's Social Security Number. A parent's Social Security Number (SSN) on the application is optional. If provided, Florida KidCare uses the SSN for computer matches with other agencies and contractors and it may help speed up your child's application processing. We will not share your information with the Immigration and Naturalization Service (INS).



SECTION 2. CHILD INFORMATION.

This information helps Florida KidCare determine if your children might qualify for lower cost or no-cost coverage.

- Answer the *shaded* questions in Section 2 for each child who lives with you. For an unborn child, write "unborn" in the First Name box and answer Relationship to Parent One, Relationship to Parent Two and if you are applying for Florida KidCare. Leave the rest of the questions blank for the unborn child. After your baby is born, call Florida KidCare to give the rest of the application information.
- Answer *all* of the questions in Section 2 for each child who needs Florida KidCare health insurance.

Child's Social Security Number (SSN). If you have an SSN for your child, write it on the application. SSNs are used to do computer matches with other agencies.

If your child does not have an SSN, write the date you applied for or tried to apply for an SSN on the application. To apply for an SSN for your child, call the Social Security Administration at 1-800-772-1213. If you have access to the Internet, go to www.ssa.gov for help applying for an SSN.

Child's Citizenship. Mark "yes" if your child is a U.S. citizen.

Important Information for Immigrants. Non-citizen children may be eligible for Florida KidCare. If your child is not a U.S. citizen, write the child's date of entry into the U.S. and the child's INS number. Make a copy of the front and back sides of any of the following papers you have for each child you are applying for Florida KidCare and attach the copies to the application:

- Form I-551/I-515 (Green Card, Permanent Resident or Resident Alien Card)
- Form I-94 (Arrival/Departure Record)
- Passport stamped by INS showing immigration status or immigrant visa, including the bearer's name and picture
- Form I-571 (Travel Authorization)
- Notice of INS receipt of Form I-589 (Asylum Application)
- Other documentation of status, like a letter from INS or judge, or a Laissez-Passer

Important Public Charge Information. What you tell us about your child's citizenship status is *confidential*. Florida KidCare will not share anything you tell us with the Immigration and Naturalization Service (INS) or any other federal agency. Information about a parent's immigration status is not needed to apply for Florida KidCare. A child's enrollment in Florida KidCare does not harm anyone's application for citizenship or legal permanent resident status.

Questions? Call 1-888-540-5437 (TTY 1-877-316-8748). This is a free call.

www.floridakidcare.org

Child's Race. Using one of these choices, write the child's race on the application:

- White
- Black/African-American
- American Indian/Alaska Native
- Asian, Hawaiian or Pacific Islander
- Hispanic
- Other

This information is optional and is not used for determining eligibility. If provided, it is used for research and to ensure all people are treated fairly.

SECTION 3 through SECTION 7.

Please follow the directions on the application.

How much do I pay each month for coverage?

- There is no charge for Medicaid for children (KidCare Medicaid).
- For other Florida KidCare programs, monthly premiums depend on your household's size and income. Most families pay \$15. If you need to pay more, we will let you know.
- You may have to pay small charges or co-payments for some services.
- A child who is a member of a federally recognized American Indian or Alaska Native tribe may qualify for no-cost Florida KidCare coverage. Call 1-888-540-5437 for more information.

What goes with the application?

Before you send in your application, make sure you have answered all of the questions and signed and put the date on the application. The application is not complete without your signature (Section 7 on the application).

- If you decide to send in a check or money order with the application, make it payable to Florida KidCare for \$15. Be sure to include the child's (or children's) name on the check.
- If your child is not a U.S. citizen, attach a copy of the front and back sides of immigration documents for each child you are applying for Florida KidCare to the application.
- If your child is an American Indian or Alaska Native, attach a copy of the front and back sides of your child's tribal identification card or other similar tribal documents to the application.

Mail the application to:

Florida KidCare
P.O. Box 980
Tallahassee, FL 32302-0980

What happens after I send in the application?

When we receive your application, we will let you know. It will take several weeks to process the application. We will check to see if your children might be eligible for Medicaid. If your children are eligible for Medicaid, you will receive more information. If any of your children are eligible for the other Florida KidCare programs, we will let you know. You may ask for a review of a decision if you think the decision was unfair or incorrect. Call 1-888-540-5437 for information.

When does coverage start?

- **MediKids and Healthy Kids:** Coverage starts after the application is *processed and approved*. Florida KidCare will let you know when the insurance coverage starts. MediKids and Healthy Kids will not pay for medical services your children received before the coverage starting date.
- **Children's Medical Services Network:** Coverage starts after the application is *processed and approved*. Florida KidCare will let you know when the insurance coverage starts. Children's Medical Services Network services *may* start sooner if your child has an emergency health care need.
- **Medicaid:** If your children qualify for Medicaid, coverage starts in the *month your application is received*. Medicaid may also pay for some medical services your children have already received.

Important Information about Medicaid

The following is important information about your rights and responsibilities you need to know if your children are eligible for Medicaid:

- The information I give on the application is true and correct to the best of my knowledge. I realize that if I give information that isn't true or if I withhold information and my children get health benefits for which they are not eligible, I can be lawfully punished for fraud. I may also have to pay Medicaid back.
- I understand that the information I give about our income and family situation will be checked, including computer matches. I agree to let the Department of Children and Families get needed information. I agree, under penalty of perjury, that everything on the application is true as best I know it. I know that Social Security numbers we provide will be used to check our income.
- I agree to notify the Department of Children and Families within 10 days if there are any changes in: the people who live in our home; where we live or get our mail; our income; or our health insurance.
- I understand that if my children are not found eligible for Medicaid using the Florida KidCare application, I can contact the local office of the Department of Children and Families to see if my children are eligible for Medicaid on some other basis.
- I give permission for Medicaid to: share medical information on my children with any insurance company to get the medical bills paid; and collect payments from anyone who is supposed to pay for that care.
- I know that Medicaid cannot discriminate because of race, color, sex, age, disability, religion, nationality, or political belief.
- I know that I can ask for a Fair Hearing from my Department of Children and Families worker if I think the decision made on my case is unfair, incorrect, or made too late.

Need help with child support?

Call 1-800-622-5437. This is a free call.