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DATE: April 1, 1998

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 4415

RELATING TO: Children's Health

SPONSOR(S): Committee on Health Care Services, Rep. Albright, and others

COMPANION BILL(S): SB 1228 (Compare)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 10 NAYS 0
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I. SUMMARY:

This bill creates the "Florida Healthy Bodies Program" which provides health insurance coverage to uninsured children with incomes up to 200% of the federal poverty level. The "Healthy Bodies" program consist of the following components:

- Medikids, a newly created program to provide services to children from birth to the age of 6 years. The Medikids program uses the Medicaid benefit package and has periodic open enrollment periods. After being determined eligible for the program, a child enrolls in a Medicaid managed care plan or MediPass. Serves 28,000 kids at a total first year cost of $15 million.

- Florida Healthy Kids, which serves children ages 6 through 19 years. Local match requirements will be modified so that all counties will be able to participate in Healthy Kids. The Healthy Kids benefit package will be used and there will be open enrollment periods during which children will select from among participating plans. Serves 157,000 kids and costs $93 million.

- Medicaid coverage for kids age 15 through 19, from 28% to 100% of federal poverty. This component will serve 30,000 kids at an annual cost of $19 million.

- Family coverage for kids in families with access to dependent coverage. Federal law authorizes a voucher payment to families with multiple children eligible for Title XXI who have access to dependent coverage through a private employer, if the coverage is more cost effective than participation in the regular Healthy Bodies program.

- A health insurance pilot project to be conducted in one county to test the feasibility of allowing all interested Florida licensed insurers and HMOs to provide child health coverage.

Children with special health care needs will be served through the Children's Medical Services network (10,000 kids / $53 million), or for children with serious emotional disturbances or substance dependency through the Department of Children and Family Services (400 kids / $5.3 million).

In all, the program is expected to cover 265,000 children at a total cost of $347 million ($119 million state and $211 million federal, and family contributions of $17 million).

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

State Children's Health Insurance Program

As a part of the federal Balanced Budget Act of 1997, Congress created Title XXI of the Social Security Act which is titled the State Children's Health Insurance Program. A summary of this new program as it applies to Florida is as follows.

PURPOSE. To provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children.

ELIGIBILITY. In general, Florida may include in the new eligibility group, children up to age 19, who meet the following criteria:

- Have a family income up to 200% of FPL; unless they are age less than 1, are pregnant or in the post partum period, the family income may be up to 235% of FPL.
- Are not eligible for Medicaid (Medicaid eligibility standards may not be reduced from their 7/97 levels).
- Are not covered by private group health insurance, or eligible for coverage under the state employee group health insurance plan.

Eligibility standards may not: discriminate on the basis of diagnosis; cover children with higher family income without covering children with a lower family income; or deny eligibility based on a child having a preexisting medical condition.

NONENTITLEMENT. This program shall not be construed as providing an individual with an entitlement to child health assistance under this program.

BENEFITS. Health benefits provided under this program must be equivalent to one or more of the following benchmark benefit packages:

- The Federal Employee Health Benefit package (a Blue Cross/Blue Shield PPC plan);
- The State of Florida employee health benefit package;
- The benefit package for the HMO with the largest insured commercial, non-Medicaid enrollment of covered lives in Florida;

Or, the benefits must equal BENCHMARK-EQUIVALENT COVERAGE, which is a benefit package that includes all of the following basic services: inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray, and well-baby and well-child care (including age appropriate immunizations); and the following additional services: prescription drugs, mental health, vision, and hearing. States may go beyond these services. However, the basic services contained in the benefit package must have an actuarial value equivalent to the benchmark benefit package; and

the additional services must have an actuarial value that is equal to at least 75 percent of the coverage of that category of services in the benchmark benefit package.

Or, health benefits coverage as provided by the Florida Healthy Kids Corporation on October 1, 1997.

Or, any other health benefits coverage approved by the Secretary of HHS.

Abortion may only be covered if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

COST-SHARING. Cost-sharing (premiums, copayments, or deductibles) is permitted with limitations as follows:

- Any cost-sharing charges must be imposed pursuant to a public schedule.
- Cost-sharing may only be imposed in a manner that does not favor children from families with higher income over children from families with lower income.
- Copayments or deductibles may not be imposed on well-baby or well-child care, including age appropriate immunizations.
- For children in families with an income below 150% FPL certain limits are placed on cost-sharing. (These limitations are consistent with current restrictions placed on adult Medicaid recipients.)
- For children in families with an income above 150% FPL, cost-sharing may not exceed 5% of the family's income for the year.

FUNDING. The total federal appropriation for the program is $4.275 billion for 1998-2001 and $3.15 billion for 2002. (This lower figure was used in order to achieve a balanced federal budget in 2002.) There is a commitment to continue funding the program beyond 2002.

The amount to be received by each state is calculated by a formula using the number of uninsured children and total children in families with incomes below 200% FPL plus a state cost factor. Current estimates are that just under 260,000 children in Florida meet the eligibility criteria for Title XXI.

Florida's annual allocation is $270 million for the first three years of the program and then slightly less for years four and five. The match rate for Florida is 69% federal and 31% state. In order to draw down our entire federal share, we will have to put up $121 million in matching funds.

Funds allocated to a state are available for two years, after which the funds will be allocated to states which have spent their funds. In order to reserve first year funding, a state must have its Title XXI plan approved by October 1, 1998.

STATE OPTIONS FOR SERVICE DELIVERY. Florida has several options available for implementing Title XXI as follows:

- ♦ Expand Medicaid eligibility to all or a portion of the children who meet the eligibility criteria for Title XXI.
- ♦ Create a new Title XXI program for eligible children using the Medicaid administrative structure to enroll providers, determine eligibility and pay claims.
- ♦ Expand the Florida Healthy Kids Corporation.
- ♦ Create a voucher program which allows the parents of Title XXI eligible children to purchase a health insurance policy for the child through the private market.
- ♦ Any combination of the above.

The Legislature and the Governor agreed to expand Healthy Kids as a starting point for Title XXI in Florida. In addition, Florida's initial Title XXI plan extends Medicaid coverage to children ages of 15 to 19 with an income between 28% and 100% of the federal poverty level. Florida's initial plan was submitted to the federal Department of Health and Human Services on December 2, 1997 and approved effective April 1, 1998.

Insurance Coverage Issues

The Employee Benefit Research Institute [Facts from EBRI 7/97] reports that the percentage of children ages 0-17 with employment-based health insurance coverage declined steadily from 66.7 percent in 1987 to 58.6 percent in 1995. Despite this trend, the percentage of children without any form of health insurance coverage barely increased. In 1987, 13.1 percent of children were uninsured nationally, compared with 13.8 percent in 1995. Medicaid program expansions helped alleviate the effects of the decline in employment-based health insurance coverage among children and the potential increase in the number of uninsured children. Between 1987 and 1995, the percentage of children enrolled in the Medicaid program nationally increased from 15.5 percent to 23.2 percent.

In 1996, only 66 percent of U.S. children younger than 18 --47 million-- were covered by private health insurance. Most private insurance for children is acquired through a parent's employer. However, in 1993, almost one-fourth of the workforce worked for an employer that did not cover dependents. In addition, even if employers offer coverage, the amount that employees have to pay toward coverage for their families may make health insurance unaffordable. Since the late 1980's, workers' costs for family coverage have risen sharply.

In 1996, 10.6 million children (14.8 percent) were uninsured, living generally in lower-income working families. Compared with privately insured children, a higher proportion of their parents worked for small employers--the group least likely to offer health insurance. In 1993, only a quarter of employees in firms with fewer than 10 employees and about half in firms with 10 to 24 employees reported that their employer offered a health insurance plan for workers and their dependents, compared with 89 percent in firms with 1,000 or more employees.

Florida has one of the nation's largest uninsured populations. Nearly 23 percent of those below the age of 65 are uninsured. Of Florida's 2.8 million uninsured non-elderly residents, approximately one-third are children. More than 823,000 of Florida's 3 million children are not insured for health care. Despite eligibility expansions in the Medicaid program and an increase in enrollment in the Florida Healthy Kids Corporation, more than 823,000 children remain uninsured. Of this number, an estimated 293,885 live in families that are potentially Medicaid eligible due to family income being below 100 percent of the federal poverty level; 259,336 live in families with income between 101 and 200 percent of the federal poverty level; and 270,246 live in families with income in excess of 200 percent of the federal poverty level. (The current federal poverty level for a family of 4 is $16,450.)

Many experts believe that the lack of health insurance discourages families from seeking preventive and other needed care for their children. These uninsured children are typically treated for urgent or emergency conditions in inappropriate settings and do not share the continuity of care enjoyed by their insured peers. The U.S. General Accounting Office [Health Insurance: Coverage Leads to Increased Health Care Access for Children (Letter Report, 11/24/97, GAO/HEHS-98-14)] has recently reported that health insurance increased children's access to health care services in almost all the studies analyzed. Most evaluations show that insured children are more likely to have preventive and primary care than uninsured children. Insured children are also more likely to have a relationship with a primary care physician and to receive required preventive services, like well-child checkups, than uninsured children. Differences in access between insured and uninsured children hold true even for children who had chronic conditions and special health care needs.

Overview of the Florida Medicaid Program

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and Florida counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for administration of the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S.

Federal law requires coverage of certain mandatory eligibility groups and gives states the option of covering certain optional groups. Likewise, federal law specifies both mandatory and optional benefits. These mandatory and optional coverage groups are specified in ss. 409.903 and 409.904, F.S., respectively. Mandatory and optional benefits are specified in ss. 409.905 and 409.906, F.S., respectively.

The Florida Medicaid Program has grown from an appropriation of $.581 billion in state fiscal year 1981-82, to $4.852 billion in fiscal year 1992-93, to $6.914 billion in the current fiscal year. After experiencing double-digit inflation throughout the late 1980's and early 1990's, the rate of growth in Florida's Medicaid Program slowed to record lows in the mid-1990's. Analysts attribute the decline in growth to a number of factors, including more extensive managed care enrollments, declining caseloads, lower overall health care inflation rates, a crackdown on program fraud, and substantial budget reductions by the Legislature. In 1995-96 and 1996-97, the Legislature reduced the Medicaid budget by nearly $470 million.

Eligibility for Medicaid is a cumbersome process, linked primarily to public assistance and based on income, assets, and categorical distinctions such as age, family composition, and health status. Currently, Florida Medicaid covers the following groups of pregnant women and children: pregnant women and children under age 1 up to 185 percent of poverty; children between the ages of 1 to 6 up to 133 percent of poverty; and children between the ages of 6 to 15 up to 100 percent of poverty. Children ages 15 to 19 are covered up to 28 percent of poverty. Under existing federal law, states' Medicaid programs must cover all children born after September 30, 1983, beginning October 1, 2001, with a family income up to 100 percent of the federal poverty level. As with many other states, Florida has taken an incremental approach to this coverage requirement, increasing the coverage of children up to 100 percent of the federal poverty level by year as children age. Fourteen year olds in families with income up to 100 percent of the federal poverty level just became eligible October 1, 1997. (For purposes of illustration, the current federal poverty level for a family of four is $16,450.) The program is projected to serve 1,490,047 clients this year, approximately half of whom, or more than 745,000, are children.

Section 409.9122, F.S., requires that most Medicaid recipients be enrolled in an HMO or MediPass (a case managed fee-for-service program). According to the provisions of the section, the agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid recipients who are: in an institution; enrolled in the Medicaid Medically Needy program; or eligible for both Medicaid and Medicare. However, to the extent permitted by federal law, the agency may enroll in a managed care plan or MediPass a Medicaid recipient who is exempt from mandatory managed care enrollment, provided that certain conditions are met.

Medicaid recipients must be given a choice of managed care plans or MediPass. Prior to requesting a Medicaid recipient who is subject to mandatory managed care enrollment to make a choice between a managed care plan or MediPass, the recipient is provided choice counseling. Medicaid recipients who are already enrolled in a managed care plan or MediPass are offered the opportunity to change managed care plans or MediPass providers on a staggered basis. All Medicaid recipients have 90 days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice are assigned to a managed care plan or MediPass based proportionately on the preferences of recipients who have made a choice in the previous period.

Florida Healthy Kids Corporation

The Legislature created the Florida Healthy Kids Corporation (FHKC) Act in 1990 (s. 624.91, F.S.) to provide school-based comprehensive health insurance to uninsured children. The not-for-profit corporation is exempt from the Florida Insurance Code and the rules of the Department of Insurance. However, the Department of Insurance may require the corporation's marketing representatives to be appointed as representatives of the insurers or providers with which the corporation contracts.

Eligibility for the subsidized part of the program is based on eligibility for the federal School Lunch Program, which is 185 percent of the federal poverty level. All families, regardless of income, are required to contribute based on their ability to pay. Premiums for children whose family incomes are above 185 percent of the federal poverty level are fully paid by the family, with no subsidy.

The program is financed by a combination of state, local, and participant funds. Local governments are required to make a financial commitment. Historically, there has been a 5 percent minimum contribution set as the base, and each program's local contribution is increased over time up to a maximum of 40 percent. At its October 1997 meeting, the board agreed to reduce the maximum local match requirement to 20 percent, contingent on new federal Title XXI funding.

Healthy Kids Corporation is operational in 23 counties, providing coverage to more than 48,000 school-age children currently, with enrollment estimated to reach 59,000 by the end of the state fiscal year, assuming current program plans. An additional 5 counties will begin enrollment in the Spring of 1998, and another 6 counties have expressed an interest in participating in the program.

The corporation issues bids to providers and insurers to participate in those counties where it is in operation. Currently, all of the contractors are managed care organizations and the average monthly Healthy Kids premium is about $55 per month.

Overview of Children's Medical Services

Under the authority of chapters 383 and 391, F.S., the Children's Medical Services (CMS) Office of the Department of Health provides a comprehensive system of care ranging from prevention services to long-term care services for financially-eligible high-risk pregnant women, sick or low birthweight newborns, and children with chronically handicapping or potentially handicapping conditions. Prevention services are available through statewide programs such as infant metabolic screening, infant hearing screening, and poison control centers. Prevention services also include the statewide Regional Perinatal Intensive Care Centers (RPICC) Program, which provides specialized services to high-risk pregnant women and newborns. Early intervention services are available throughout the state for infants and toddlers who are at risk for developmental delay. These services are provided by local agencies and Developmental Evaluation and Intervention programs.

Eligible individuals may receive medical and support services through local CMS clinics staffed by private contract physicians, in local private physician offices, or other local health care organizations, through regional programs, hospitals, referral centers, and statewide programs. Specialty clinics are available for a wide range of medical problems. Children are referred from local physicians and specialty clinics into regional and tertiary programs for such problems as kidney disease, diabetes, and cancer. Children with medically complex problems receive specialized community-based services and long-term care such as medical foster care, developmental and medical care, in-home services, and skilled nursing facility care. The continuum of CMS services is organized as a formal network of providers throughout the state. Providers and families are supported by nurse case managers and social workers.

Section 409.9126, F.S., created by chapter 96-199, Laws of Florida, authorizes the statewide Children's Medical Services network of providers to serve Medicaid-eligible children with special health care needs, pursuant to federal waiver approval. Network providers are reimbursed on a fee-for-service basis for such services. The term "children with special health care needs" is specifically defined. Such children are assigned to a CMS network provider, who serves as the child's service gatekeeper. Rules for the network are developed by AHCA, in conjunction with the Department of Health.

The provisions of part I of chapter 391, F.S., which establish the CMS program are lacking in legislative direction. Essential elements of the program, including income and eligibility standards, services to be included in the benefit package, and reimbursement methods, are not specified in statute. Rather, responsibility for determining these program elements is delegated to the Department of Health. Other essential program elements, including third party liability, grievance reporting and resolution procedures, and authority for a program integrity office to prevent fraud and abuse, are absent from the statutes entirely.

B. EFFECT OF PROPOSED CHANGES:

All children in Florida with a family income below 200 percent of the federal poverty level ($32,900 per year for a family of four), who do not have private health insurance or whose parents are not employees of a government agency, will be eligible for a state subsidized insurance plan. Children eligible for Medicaid must participate in the Medicaid program. Children with family incomes above Medicaid eligibility but below 200 percent of federal poverty from birth to age 6 will be eligible to enroll in the Medikids program, a program which provides the Medicaid benefit package using existing Medicaid managed care plans. Older children will be eligible to enroll in the Healthy Kids program, which provides health benefits through private insurance plans or HMOs by competitive bid in each county of the state.

Children with special health care needs will be served through the Children’s Medical Services network which will provide specialty care on a capitated basis through contracts with managed care providers. Children with serious emotional disturbances or substance dependency will be served through the Department of Children and Family Services.

Statutory authority for the CMS program will be revised to clearly establish eligibility standards, the benefit package, reimbursement methods, and authority for a third party liability and program integrity system. Eventually, all CMS care will be provided through capitated arrangements.

Medicaid recipients who are children up to the age of 19 years will have continuous Medicaid eligibility for 6 months. Efficiency of medical care delivery should be improved.

Children will have improved access to direct service providers, including the school health service program and the Primary Care for Children and Families Challenge Grant program, due to increased funding of these programs with Title XXI dollars.

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

   a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes, the following state agencies are given both the authority and duty to implement provisions of this act, including rule making authority: The Department of Health, the Department of Insurance, the Department of Children and Family Services, and the Agency for Health Care Administration.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, the Florida Healthy Kids Corporation is given additional responsibilities for the implementation of this legislation. Private insurance companies and HMOs wishing to participate in service delivery will be given that opportunity.

(3) any entitlement to a government service or benefit?

This bill does not create entitlements except for accelerating Medicaid eligibility for children ages 15 through 19 with a family income between 28 and 100 percent of federal poverty.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

The bill does authorize fees in the form of limited premiums and copayments for program participants.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Yes, through premiums and coinsurance.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

No.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

Parents are responsible for determining whether they want their children to participate in the program.

(2) Who makes the decisions?

The parents.

(3) Are private alternatives permitted?

Yes, all service delivery is done by the private sector.

(4) Are families required to participate in a program?

No.

(5) Are families penalized for not participating in a program?

No.

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

ss. 383.011, 391.011, 391.016, 391.021, 391. 025, 391.026, 391.051, 391.028, 391.046, 391.07, 391.029, 391.031, 391.036, 391.041, 391.035, 391.045, 391.047, 391.055, 391.065, 391.071, 391.081, 391.095, 391.061, 391.097, 391.201 - 391.217 renumbered as 400.901 - 400.917, 391.221, 391.222, 391.223, 391.301, 391.303, 391.304, 391.305, 391.307, 408.701, 409.810, 409.811, 409.812, 409.813, 409.8131, 409.8134, 409.8135, 409.814, 409.815, 409.816, 409.817, 409.8175, 409.818, 409.819, 409.8195, 409.820, 409.821, 409.904, 409.9126, 641.91, 391.031, 391.056, 391.091, and 624.92, F.S.

E. SECTION-BY-SECTION RESEARCH:

Section 1. Amends s. 383.011, F.S., relating to administration of maternal and child health programs, to authorize AHCA and the Department of Health to seek a federal waiver to secure Medicaid matching funds for the Healthy Start program.

Section 2. Amends s. 391.011, F.S., relating to children's medical services, to provide that this chapter may be cited as the "Children's Medical Services Act."

Section 3. Amends s. 391.016, F.S., relating to children's medical services, to provide legislative intent for the Florida Children's Medical Services program as follows: 1) to provide to children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care which links community-based health care with multi-disciplinary, regional, and tertiary pediatric specialty care; 2) to provide essential preventive, evaluative and early intervention services for children at risk for having special health care needs in order to prevent or reduce long tern disabilities; 3) to serve as principal provider for children with special health care needs under Titles XIX and XXI of the Social Security Act; and 4) to be complementary to children's health training programs essential for the maintenance of a skilled pediatric health care workforce.

Section 4. Amends s. 391.021, F.S., relating to children's medical services, to add definitions for "Children's Medical Services network", "children with special health care needs", "health care provider", "health services", "participant", and "program". This section also changes all references to "medical services" in this act to "health services."

Section 5. Creates s. 391.025, F.S., to provide for the applicability and scope of the health services provided by the Children's Medical Services act. The act applies to: individuals enrolled in the Medicaid program; individuals enrolled in the Florida Children's Healthy Bodies program; and uninsured or underinsured individuals who meet established eligibility requirements. The Children's Medical Services program consists of: the infant metabolic screening program; the Regional Perinatal Intensive Care Centers program; the Developmental Evaluation and Intervention program, and the Children's Medical Services network. This section also exempts the Children's Medical Services program from the requirements of the Florida Insurance Code.

Section 6. Amends s. 391.026, F.S., relating to children's medical services, to provide duties for the Department of Health in carrying out the provisions of the Florida Children's Medical Services program. These duties include to: determine the medical and financial eligibility standards for the program and to determine the medical and

financial eligibility of individuals seeking health services from the program; determine the medical and financial eligibility standards for the program and to determine the medical and financial eligibility of individuals seeking health services from the program; oversee and operate the Children's Medical Services network; establish reimbursement mechanisms for the Children's Medical Services network; establish Children's Medical Services network standards and credentialing requirements for health care providers and health care services; serve as a provider and principal case manager for children with special health care needs under Titles XIX and XXI of the Social Security Act; monitor the provision of health services in the program, including the utilization and quality of health services; administer the Children with Special Health Care Needs program in accordance with Title V of the Social Security Act; establish and operate a grievance resolution process for participants and health care providers; maintain program integrity in the Children's Medical Service program; receive and manage health care premiums, capitation payments and funds from federal, state, local, and private entities for the program; appoint health care consultants for the purpose of providing peer review and making recommendations to enhance the delivery and quality of services in the Children's Medical Services program; and make rules to carry out the provisions of the act.

Section 7. Amends and renumbers s. 391.051, F.S., as s. 391.028, F.S., to provide for administration for the Children's Medical Services program, to set qualifications for directors, and to establish operational activities to be performed by the Children's Medical Services area offices. The activities shall include, but are not limited to: providing case management services for the network; providing local oversight of the program; determining medical and financial eligibility; participating in the determination of a level of care and medical complexity for long-term care services; authorizing services in the program and developing spending plans; participating in the development of treatment plans; and taking part in the resolution of complaints and grievances from participants and health care providers. The section also establishes qualifications for the CMS area office director who must be a Florida licensed medical or osteopathic physician with specialized training and experience in the provision of health care to children. Each area office director is appointed by the director of the Division of CMS.

Section 8. Amends and renumbers ss. 391.046 and 391.07, F.S., as s. 391.029, F.S., relating to children's medical services, to provide that the department shall establish the program's criteria for medical eligibility. The following persons are financially eligible: a high risk pregnant woman who is eligible for Medicaid; a child with special health care needs who qualifies for Medicaid or a Title XXI program; and a child with special health care needs who meets spend down criteria. The department may continue to cover children over the age of 21 who are receiving services under the program on or before April 1, 1998 until July 1, 2000.

Section 9. Creates s. 391.031, F.S., to establish that benefits of the program shall be the same benefits offered to children under Medicaid. The department is authorized to offer additional benefits for early intervention services, respite services, and parent services if such services are determined to be medically necessary. The section specifies that no child who is eligible for Title XIX or XXI may receive any service other than an initial health screening or treatment for an emergency medical condition, until the person enrolls in Title XXI or Medicaid.

Section 10. Amends and renumbers ss. 391.036 and 391.041, F.S., as s. 391.035, F.S., to direct the department to establish the criteria for selecting health care providers to participate in the Children's Medical Services network and to require that all health care providers under contract with the program be licensed in the state.

Section 11. Creates s. 391.045, F.S., to establish that reimbursement to health care providers for services rendered through the network be cost-effective, and include, but not be limited to, capitations, discounted fee-for service, unit costs, and cost reimbursement. Medicaid reimbursement rates are to be utilized to the maximum extent possible where applicable. Reimbursement to the CMS program for participants in the Healthy Bodies program must be on a capitated basis.

Section 12. Creates s. 391.047, F.S., to provide that the program comply with s. 402.24, F.S., when payments on behalf of the program involve third-party liabilities and recovery of third-party payments for health services. Section 402.24, F.S., establishes standards for recovery of third-party payments for medical services.

Section 13. Creates s. 391.055, F.S., to establish service delivery systems for the program including managed care methods and contracts with school districts participating in the certified school match program. The components of the network include: qualified primary care physicians who serve as gatekeepers and are responsible for the provision or authorization of health services to an eligible individual enrolled in the program; comprehensive speciality care arrangements; and case management services.

Section 14. Creates s. 391.065, F.S., to authorize the department to establish health care provider agreements for participation in the network.

Section 15. Creates s. 391.071, F.S., to require the program to develop quality of care integration standards and reporting requirements for health care providers participating in the network and to ensure that the standards are not duplicative of other health care provider requirements.

Section 16. Creates s. 391.081, F.S., to require the department to adopt and implement a system for resolving complaints and grievances of eligible individuals and health care providers using existing grievance reporting and resolution processes to the greatest extent possible.

Section 17. Creates s. 391.095, F.S., to establish that the department operate a system for promoting program integrity in which the department oversees the activities of the network participants, health care providers, and their representatives to prevent fraud and neglect of participants, and to recover overpayments.

Section 18. Amends and renumbers s. 391.061, F.S., as s. 391.097, F.S., to include evaluation projects in the type of projects implemented by the department to improve the delivery of children's medical services, and to establish that the Children's Medical Services network be included in any evaluation conducted in accordance with the provisions of Title XXI of the Social Security Act.

Section 19. Renumbers ss. 391.201 through 391.217, F.S., relating to prescribed pediatric extended care centers, to ss. 400.901 through 400.917, part IX of chapter 400, F.S.

Section 20. Renumbers s. 391.206, F.S., as s. 400.906, F.S., and amends said section to correct a cross reference.

Section 21. Renumbers s. 391.217, F.S., as s. 400.917, F.S., and amends said section to correct cross references.

Section 22. Designates ss. 391.221, 391.222, and 391.223, F.S. as part II of chapter 391, F.S., entitled "Children's Medical Services Councils and Panels."

Section 23. Creates s. 391.221, F.S., to create authority for the secretary of the department to establish the Statewide Children's Medical Services Network Advisory Council and to establish membership requirements. The council's duties shall include, but not be limited to: recommending standards and credential requirements for health care providers rendering health services to network participants; making recommendations to the director of the Division of Children's Medical Services concerning the selection of health care providers for the network; reviewing and making recommendations concerning network health care provider or participant disputes; providing input to the Children's Medical Services program in the policies governing the network; reviewing the financial reports and financial status of the network and making recommendations concerning methods of payment and cost controls for the network; reviewing and recommending the scope of benefits for the network; and reviewing network performance measures and outcomes and making recommendations for improvements to the network and its collections of data. The council is to be composed of 12 members representing the private health care provider sector, families with children who have special health care needs, AHCA, the Dept. of Insurance, the Florida Chapter of the American Academy of Pediatrics, an academic health center pediatric program, and the health insurance industry. Members are appointed for a 4-year term and may be reappointed once.

Section 24. Creates s. 391.222, F.S., to create authority for the secretary of the department to establish the Cardiac Advisory Council and to establish membership requirements. The council's duties shall include, but are not limited to: recommending standards for personnel and facilities rendering cardiac services for Children's Medical Services; receiving reports of review of cardiac personnel and facilities to determine if established standards are met; making recommendations to the Children's Medical Services director regarding the approval or disapproval of reviewed personnel and facilities and regarding the intervals for reinspection; and providing input to Children's Medical Services on all aspects of cardiac programs, including the rule making process. The council is to be composed of 8 members with technical expertise in cardiac medicine. Members are appointed for 4-year terms and may serve two consecutive terms.

Section 25. Creates s. 391.223, F.S., to create authority for the secretary of the department to establish technical advisory panels to assist the program in developing specific policies and procedures for the program.

Section 26. Amends s. 391.301, F.S., relating to developmental evaluation and intervention programs, to provide for technical revisions.

Section 27. Amends s. 391.303, F.S., relating to developmental evaluation and intervention programs, to provide for technical revisions.

Section 28. Amends s. 391.304, F.S., relating to developmental evaluation and intervention programs, to provide for technical revisions.

Section 29. Amends s. 391.305, F.S., relating to developmental evaluation and intervention programs, to provide for technical revisions.

Section 30. Amends s. 391.307, F.S., relating to developmental evaluation and intervention programs, to provide for technical revision.

Section 31. Amends s. 408.701, F.S., to correct a cross reference.

Section 32. Creates s. 409.810, F.S., providing the short title, "The Florida Children's Healthy Bodies Act."

Section 33. Creates s. 409.811, F.S., providing definitions of 28 relevant terms.

Section 34. Creates s. 409.812, F.S., providing legislative findings and intent and guiding principles for the Florida Children's Healthy Bodies program. Guiding principles include: the fact that the program is not an entitlement; participants be given a choice of plans and physicians; interference in the private market be minimized; children in families with incomes above eligibility levels be permitted to "buy in" to the program; and special emphasis be placed on minority participation.

Section 35. Creates s. 409.813, F.S., to specify program components; the nonentitlement nature of the program; and enrollment ceilings. Program components of the Florida Children's Healthy Bodies program include: Medicaid coverage for children age 15 through 19 years with incomes between 28% and 100% of the federal poverty level; Medikids for children from birth to age 6 years with incomes up to 200% of the federal poverty level; the Florida Healthy Kids program for children age 6 through 19 years with incomes up to 200% of the federal poverty level; health insurance plans certified and approved to participate in the private health insurance demonstration project created under the act; the Children's Medical Services network; and Family coverage authorized under the act. This section requires an enrollment ceiling for the program be placed in the General Appropriations Act each year and that all new enrollment in the program cease any time the Social Services Estimating Conference determines funds are insufficient to finance current or projected enrollment.

Section 36. Creates s. 409.8131, F.S., the Medikids program. Specifies the following:

(1) Legislative findings and intent - Medikids is to provide health services to eligible children utilizing the administrative structure and provider network of the Medicaid program while avoiding the creation of an entitlement program.

(2) Program creation - Medikids is created within the Division of State Health Purchasing in AHCA and is not subject to the requirements of the Department of Insurance or chapter 627, F.S.

(3) Non-entitlement - Medikids is not an entitlement program.

(4) Marketing - Authorizes the agency, in consultation with the DOH, to develop and implement a plan to publicize Medikids.

(5) Applicability - The provisions of the following sections of chapter 409, F.S., apply to Medikids to the same extent such sections apply to Medicaid: .902 relating to designated single state agency, payment requirements, program title; .905 relating to mandatory Medicaid services; .906 relating to optional medical services; .907 relating to Medicaid provider agreements; .908 relating to reimbursement; .910 relating to responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable; .912 relating to cost-effective purchasing of health care; .9121 relating to legislative findings and intent; .9122 relating to mandatory Medicaid managed care enrollment, programs and procedures; .9123 relating to quality-of-care reporting; .9124 relating to managed care reimbursement; .9127 relating to preauthorization and concurrent utilization review, conflict-of-interest standards; .9128 relating to requirements for providing emergency services and care; .913 relating to oversight of the integrity of the Medicaid program; 916 relating to grants and donations trust fund; .919 relating to rules; .920 relating to Medicaid provider fraud; and .9205 relating to Medicaid fraud control unit, law enforcement officers; except the applicability of the provisions of s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment are subject to the provisions of subsection (7).

(6) Benefits - Benefits provided to Medikids participants will be the same as the benefits provided to children under the Medicaid program.

(7) Eligibility - Children from birth to age 6 years with an income below 200% of the federal poverty level who do not financially qualify for Medicaid are eligible for Medikids.

(8) Enrollment - Enrollment in Medikids may only occur during open enrollment periods. Services are not provided until a child enrolls in a Medicaid HMO or MediPass.

(9) Special enrollment periods - Children who lose eligibility for Medicaid but not for Medikids, any newborn eligible for Medikids, or children who move into a new county not covered by their Medikids managed care plan will be given a 30 day special enrollment period if a slot is available.

(10) Penalties for voluntary cancellation - Authorizes the agency to establish enrollment criteria which include penalties or waiting periods of not fewer than 60 days for reinstatement of coverage upon voluntary cancellation for non-payment of premiums.

Section 37. Creates s. 409.8134, F.S., relating to delivery of services in rural counties to authorize insurers to reimburse providers in rural counties according to the Medicaid fee schedule.

Section 38. Creates s. 409.8135, F.S., relating to behavioral health services to direct the Department of Health to contract with the Department of Children and Family

Services to provide behavioral health and substance abuse services to non-Medicaid-eligible children with special health care needs.

Section 39. Creates s. 409.814, F.S., relating to eligibility for the Florida Children's Healthy Bodies program. Generally, children with a family income below 200% of the federal poverty level who do not financially qualify for Medicaid, are eligible with no assets test. Children below age 6 must enroll in Medikids and children age 6 and over must enroll in Healthy Kids, except that children under age 6 with an older sibling in Healthy Kids may enroll in that program if the county permits that option. Eligible children with special health care needs may enroll in the Children's Medical Services network. Certain children are prohibited from participating, consistent with federal requirements, including a child: eligible for coverage under state employee health benefits; covered under a group health plan; who is an alien but not a qualified alien; or who is an inmate of a public institution. Children with incomes above 200% of the federal poverty level may buy-in to the program at full cost, but are capped at not more than 10 percent of total participants.

Section 40. Creates s. 409.815, F.S., relating to health benefits coverage and limitations. For Medicaid and Medikids eligibles, Medicaid benefits are to be provided. For all others, the enhanced Healthy Kids benefit package is used. This benefit package includes the following: behavioral health limited to 30 inpatient days for psychiatric admissions or 30 days of residential services in lieu of inpatient psychiatric admissions and 40 outpatient visits, and for substance abuse limited to 7 inpatient days for medical detoxification and 30 days of residential services and 40 outpatient visits each year; durable medical equipment; emergency services; health practitioner services, including limited chiropractic and podiatric services; home health services; hospice; hospital inpatient and outpatient services, and ambulatory surgical services; laboratory and x-ray services; maternity care; nursing facility services; organ transplantation; prescribed drugs; preventive health services; therapy services; and emergency medical transportation. There is a one million dollar lifetime cap per covered child on the Healthy Kids benefit package and there are coverage exclusions for: abortion, except to save the life of the mother or in the case of rape or incest; experimental or investigational procedures; and services performed for cosmetic purposes only. The Healthy Kids benefit package is exempted from the mandated benefits and mandated offering of benefits listed in chs. 627 or 641, F.S., unless the law is made expressly applicable to the Healthy Kids Benefit package.

Section 41. Creates s. 409.816, F.S., relating to limitations on premiums and cost-sharing. In conformity with federal requirements, program participants who are Medicaid recipients may not be required to pay premiums or any cost-sharing. Other program participants with a family income below 150% of the federal poverty level may be required to pay nominal copayments, deductibles, or coinsurance and limited premiums consistent with federal regulations. Program participants with incomes above 150% of the federal poverty level may not be required to pay premiums, copayments or deductibles which exceed 5% of the family's income on an annual aggregate basis.

Section 42. Creates s. 409.817, F.S., relating to a health insurance pilot project, to direct the agency to select one urban county and establish the pilot project. Any licenced health insurer or HMO which meets qualifications may participate in the program and serve children eligible for the Healthy Kids program. These qualifications include: being certified by the DOI; being guarantee-issued; being community rated; not

imposing any preexisting conditions exclusions for covered benefits; and complying with premium and cost-sharing limitations; complying with quality assurance and access standards. This section is repealed effective October 1, 2001.

Section 43. Creates s. 409.8175, F.S., which directs the agency to establish a program for the purchase of family coverage. In establishing the program, the agency must ensure certain conditions are met, including: the child must not have had workplace coverage for the previous 6 months; state payment must be no more than the cost of the benchmark premium; and the agency must monitor the program to avoid substitution effects.

Section 44. Creates s. 409.8177, F.S., relating to program evaluation. Requires the agency to submit an annual report to the Governor and Legislature by January 1 each year. The agency is directed to contract with the Institute for Child Health Policy for the evaluation for the first 5 years. Thereafter, the evaluation contract is to be competitively bid. Specific elements to be included in the evaluation are listed.

Section 45. Creates s. 409.818, F.S., relating to administration. This section specifies duties related the Florida Children's Healthy Bodies program by department or entity:

- The Department of Children and Family Services is responsible for developing a simplified eligibility form and establishing and maintaining the eligibility determination process for Medikids.

- The Department of Health is responsible for: coordinating program outreach activities; establishing a toll-free phone line to provide consumer information; chairing a state level coordinating council; and adopting related rules.

- The Agency for Health Care Administration is responsible for: calculating the premium assistance payment levels and establishing an enhanced benchmark premium for services provided by the CMS network to non-Medicaid-eligible children; calculating the annual program enrollment ceiling; making premium assistance payments and requiring participating health plans to collect premiums and report on premiums collected; monitoring compliance with quality assurance and access standards; establishing a mechanism for investigating and resolving complaints and grievances; approving health benefits coverage for program participation; administration of the Medikids program; and adopting necessary rules.

- The Department of Insurance is responsible for: certifying health benefits plans (other than Healthy Kids plans) meet or exceed the benchmark benefit plan and that the plans will be offered at an approved rate; and adopting necessary rules.

- The Florida Healthy Kids program is responsible for its duties as set forth in s. 624.91, F.S. In addition, the program is responsible for: establishing and maintaining the eligibility determination process, excluding Medikids and Medicaid; and informing potential program participants about eligibility determinations.

This section authorizes the agency, DOH, Department of Children and Family Services, and the Florida Healthy Kids Corporation, with the approval of the Speaker of the House and the President of the Senate, to make program modifications necessary to overcome objections by the federal regulatory agency.

Section 46. Renumbers s. 154.508, F.S., as s. 409.819, F.S., and amends that section to make it applicable to the Florida Children's Healthy Bodies program and gives the Department of Health lead responsibility for program outreach, in conjunction with other agencies.

Section 47. Creates s. 409.8195, F.S., which directs the Department of Health, in consultation with AHCA, to develop quality assurance access standards for the Florida Children's Healthy Bodies program.

Section 48. Creates s. 409.821, F.S., which provides performance-based program budgeting outcome measures and standards for the Florida Children's Healthy Bodies program.

Section 49. Establishes an enrollment cap of 270,000 for fiscal year 1998-99 for the non Medicaid portion of the Florida Children's Healthy Bodies program.

Section 50. Amends s. 409.904, F.S., relating to optional eligibility groups for Medicaid, to include in the Medicaid program children age 6 through 19 years with family incomes up to 100% of the federal poverty level. In addition, the section makes Medicaid eligible children under the age of 19 continuously eligible for the program for 6 months.

Section 51. Amends s. 409.9126, F.S., relating to children with special health care needs, to require that effective July 1, 1999 reimbursement for Medicaid services must be on a capitated basis, and to authorize the agency to determine the number of enrollment slots to be served in the CMS network.

Section 52. Amends s. 624.91, F.S., relating to the Florida Healthy Kids Corporation, to do the following: add legislative intent related to serving children eligible for Title XXI of the federal Social Security Act; specify the program is not an entitlement; and make numerous technical revisions. In addition this section revises the duties and powers of the corporation as follows: requires that standards for providers do not limit primary care providers to board certified pediatricians in rural areas; establish enrollment criteria which include penalties or waiting periods of not fewer than 60 days for voluntary cancellation due to failure to pay family premiums; provide an open enrollment period for any child who loses eligibility for Medicaid or Medikids, if a space is available; establish standards under which the corporation will contract with more than one provider in program sites; provide for a base enrollment into the program in each program site without the benefit of local matching funds and vary local matching requirements based on local government's ability to provide match; establish program participation criteria which are consistent with the requirements of the Florida Children's Healthy Bodies program; and allow existing contracts which comply with federal standards to continue for up to 2 years.

Section 53. Repeals ss. 391.031, 391.056, and 391.091, F.S., relating to CMS: patient care centers; district program supervisors; and the Cardiac Advisory Council. All of these items are covered under newly created sections in ch. 391, F.S. Also repeals s. 624.92, F.S., relating to directing the agency to apply for a waiver to use Title XIX funding for Healthy Kids

Section 54. Repeals effective October 1, 2000, provisions in the act related to serving children with special health care needs through the Children's Medical Services network.

Section 55. Repeals effective October 1, 2003, the Florida Children's Healthy Bodies program.

Section 56. Provides an effective date of upon becoming a law.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

   See fiscal comments.

2. Recurring Effects:

   See fiscal comments.

3. Long Run Effects Other Than Normal Growth:

   See fiscal comments.

4. Total Revenues and Expenditures:

   See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS a WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   Local governments participate in funding the Healthy Kids program at their option. Maximum participation levels for local governments are currently set at 20 percent of total program costs.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   Participating children will be required to pay copayments and premiums.

2. Direct Private Sector Benefits:

An estimated 264,000 children will have access to health insurance. Almost all of these children will be covered by private insurers, or HMOs. Health care providers, especially hospitals, should see a dramatic reduction in the requirement to provide uncompensated charity care.

3. Effects on Competition, Private Enterprise and Employment Markets:

Competition in the private insurance market related to the provision of children's health insurance should increase dramatically.

D. FISCAL COMMENTS:

HB 4503, the House Health and Human Services General Appropriations Act, appropriates in a lump sum $75 million in tobacco settlement funds and $170 million of Title XXI and Title XIX funds for the implementation of this legislation. Additional trust fund authority may be needed.

Option	Ages	Change in Coverage	Number of Child cov 6/30/99	Total Cost	Family Contribution	Federal 69.07%	State 30.93%
Title XXI Funds							
Services (90%)							
MediKids	0 - 1	186% - 200% FPL	1,630	$2,683,294	$99,450	$1,784,661	$799,183
MediKids- Non CMS	1 - 6	134% - 200% FPL	26,586	$12,673,152	$1,620,000	$7,634,412	$3,418,740
Sub-Total				$15,356,446	$1,719,450	$9,419,073	$4,217,923
Medicaid Expansion	15 - 19	29% to 100% FPL	29,971	$19,014,372		$13,133,227	$5,881,145
Healthy Kids	6 - 19	101% to 200% FPL	157,013	$92,596,683	$13,009,050	$54,971,178	$24,616,455
Family Coverage			1,923	$510,889	$282,780	$157,555	$70,554
Rural Programs			13,880	$12,957,073	$1,278,658	$8,066,281	$3,612,134
Dental Services	6 - 19	101% to 200% FPL	157,013	$0		$0	$0
Behavioral Health Services	6 - 19	101% to 200% FPL	157,013	$1,415,385		$977,606	$437,779
CMS - Beh Hlth Network	6 - 19	101% to 200% FPL	413	$5,293,812		$3,656,436	$1,637,376
CMS - MediKids	1 - 6	134% - 200% FPL	1,399	$7,877,136	$85,275	$5,381,838	$2,410,023
CMS - Children's Ins Program	6 - 19	101% to 200% FPL	8,264	$44,743,404	$761,288	$30,378,448	$13,603,668
Sub-Total				$57,914,352	$846,563	$39,416,722	$17,651,067
Sub-Total				**$199,765,200**	**$17,136,501**	**$126,141,642**	**$56,487,057**
Outreach/Direct Cont (10%)				**$20,292,078**		**$14,015,738**	**$6,276,340**
School Health				$3,619,516		2,500,000	1,119,516
Outreach/Admin				$4,504,248		3,111,084	1,393,164
Primary Care Challenge Grants			8,449	$6,764,026		4,671,913	2,092,113
FHK/MMIS Admin				$5,404,287		3,732,741	1,671,546
TOTAL TITLE XXI			**233,312**	**$220,057,278**	**$17,136,501**	**$140,157,380**	**$62,763,397**
Title XIX Funds (55.81%)							
6 Month Continuous Elig	0 - 19	varies by age		$17,544,065		$9,791,343	$7,752,722
Medicaid Growth/Outreach	1 - 19	varies by age	80,222	$62,863,734		$35,084,250	$27,779,484
Healthy Start Services*		varies by age		$46,843,177		$26,143,177	$20,700,000
TOTAL TITLE XIX			**80,222**	**$127,250,976**		**$71,018,770**	**$56,232,206**
TOTAL ALL			**313,534**	**$347,308,254**	**$17,136,501**	**$211,176,150**	**$118,995,603**

Current Healthy Kids	(49,000)
Number of new Kids Covered	264,534

Healthy Start 9 months funding ($27,600,000.75=$20,700,000)

Source of State Share:		
Existing General Revenue		$ 37,838,368
Healthy Kids	$16,018,852	
School Hlth	$ 1,119,516	
Healthy Start	$20,700,000	
Tobacco Funds		$ 74,676,993
Local County Match	$ 6,480,241	
TOTAL		$118,995,603

Assumptions:

1. Assumes a 76% participation rate for children ages 0 - 1; 1 - 6; and 15 - 19.
2. Assumes a 75% participation rate for children ages 6 - 19.
3. Assumes a 12 month phase in of children ages 0 - 1; 1 - 6 and 15 - 19.
4. Assumes a 9 month phase in beyond 118,725 FHK cases on 9/30/98 for children ages 6 - 19.
5. Family contribution is total caseload divided by 1.6 (average family size) times $15 per family per month for 12 months.
6. Assumes 5% of children will need CMS network services.
7. Assumes .0025% of children will need CMS behavioral health network services.
8. Family Coverage assumes .39% of families with 5 or more children with an average of 5.02 children (383 families).

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

Part I of Chapter 391, F.S., was written at a time when most of the funding for the CMS program was federal block grant trust or general revenue. At that time, most services were provided based on contractual arrangements with providers groups. Beginning in the 1980's with the expansion of Medicaid, and continuing through today with the creation of Title XXI, virtually all CMS clients are eligible for coverage under a federally subsidized insurance plan. The economic advantage to the citizens of Florida of leveraging $1.22 in federal matching dollars for every dollar in state funds contributed to serve a Medicaid recipient, or $2.23 in federal matching dollars for every dollar in state funds for a Title XXI recipient, is difficult to ignore. Two to three times the number of children can be served through a Title XIX or XXI program than can be served through a general revenue only program.

Another modern cost efficiency mechanism which is lacking in CMS is managed care, and especially capitation. Managed care principles have been applied to virtually all aspects of the health care delivery system, including to workers' compensation, mental health, and even

long term care. The potential for savings and improvement in the quality of care available through managed care are even more critical in a system designed to care for chronically ill children.

However, great care must be taken in imposing modern insurance principles into an existing structure as sophisticated as the CMS program. The system as currently designed may not be as efficient as it could be, but it certainly provides the highest quality state-of-the-art care to children who, due to their economic backgrounds, would otherwise go without.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Legislative Research Director:
Michael P. Hansen	Michael P. Hansen