The Florida Senate

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Committee on Health, Aging and Long-Term Care | Senator James E. "Jim" King, Jr., President

REVIEW FLORIDA KIDCARE PROGRAM ADMINISTRATION

SUMMARY

The Florida Kidcare program provides low-cost health insurance to 1.4 million Florida children.

Kidcare is an umbrella program, the components of which are operated by the Agency for Health Care Administration, the Florida Healthy Kids Corporation, the Department of Health and the Department of Children and Families.

The State has established the Kidcare Coordinating Council as a formal mechanism to make recommendations regarding the implementation and operation of the program. The Kidcare Coordinating Council and the entities operating the Kidcare program have established regular, on-going planning geared toward making the administrative complexity of the program transparent to applicants.

As a result of a temporary decrease in the level of federal matching dollars available to Florida, the State may be required to take action to decrease expenditures in the program.

This report recommends that the entities administering the Kidcare program continue implementation of the administrative improvements they have planned; that the Legislature provide funds for an electronic data interchange between the FLORIDA system and the Healthy Kids Corporation fiscal agent; and that an automatic repeal of the Kidcare Act when certain financial triggers are reached be deleted from the statutes.

BACKGROUND

Florida's Kidcare program provides health care coverage to approximately 1.4 million children in Florida, through Medicaid, the Healthy Kids Corporation, the Medikids program, and the Children's Medical Services (CMS) Network. Kidcare is Florida's program implementing the national State Child Health Insurance Program (SCHIP) which was created in Title XXI of the Social Security Act (Title XXI).

Title XXI allocated 10 years of federal matching funds to states to provide health care coverage to low and middle income children. Under Title XXI states can provide coverage for children who have incomes higher than Medicaid eligibility limits (to a maximum of 200 percent of the federal poverty level (FPL) or at 50 percentage points above 1997 eligibility levels, whichever is higher). Title XXI also provides an enhanced federal matching rate (Florida's SCHIP match rate was set at 69 percent versus the existing Medicaid 55 percent match rate). Title XXI also allows states to develop an enhanced benefit package specifically tailored to the needs of children. Title XXI funding is block granted to the states from the federal government. In contrast to Medicaid, which is an entitlement program, SCHIP is not an entitlement. States are allowed to impose limited cost sharing (premiums, deductibles, and co-insurance) on the eligible families. Title XXI funded programs are in addition to coverage for children under Medicaid; states were not allowed to shift children from Medicaid to the new initiative. Children who are eligible for services under Medicaid are specifically prohibited from coverage under SCHIP.

States are allowed to carry forward unspent Title XXI funds for three years, after which remaining unspent funds revert to the federal government or are reallocated to states that have fully spent their allocations. Title XXI requires that 90 percent of funds be used for health insurance coverage for children; 10 percent of the total amount of federal funding may be used for outreach, administration, and other costs to administer the program.

In order to receive federal funds under Title XXI, states were required to submit "state plans" to the federal Department of Health and Human Services. The state

plans were required to describe eligibility standards, benefits, delivery methods, utilization controls, cost-sharing requirements, maintenance-of-effort, outreach efforts, administrative processes, and coordination with other coverage programs.

Title XXI allows the states considerable flexibility in the administrative design of their programs. States could expand coverage for children through the existing Medicaid program, create or expand a separate program specific to children or create a combination of these options. Florida was one of three states to have an existing child health insurance program (the Florida Healthy Kids Corporation) grandfathered in as part of the federal act.

Florida chose to create a program that is a combination of Medicaid expansions and public/private partnerships, with a wrap-around delivery system serving children with special health care needs. Florida's Kidcare system is actually four separate programs operated collaboratively: an expanded Healthy Kids program, Medikids, Medicaid for children, and the CMS Network. The Kidcare program is designed to maximize coverage for eligible children and federal funding participation for Florida, while avoiding the creation of an additional entitlement program under Medicaid.

The eligibility requirements for the four Kidcare components are as follows:

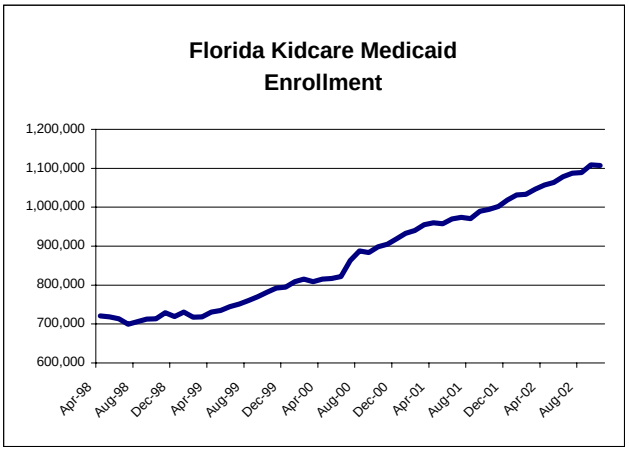
Medicaid - for children who qualify for Title XIX under the following income limits: ages 0 up to 1 up to 200 percent FPL; ages 1 up to 5 up to 133 percent of FPL; and ages 6 up to 19 up to 100 percent FPL.

Medikids - for children ages 1 up to 4 who qualify for Title XXI with incomes up to 200 percent FPL.

Healthy Kids - for children ages 5 up to 19 who qualify for Title XXI up to 200 percent FPL. A limited number of children who have family incomes over 200 percent of FPL are enrolled in the Florida Healthy Kids Corporation full-pay category. In this category, the family pays the entire cost of coverage.

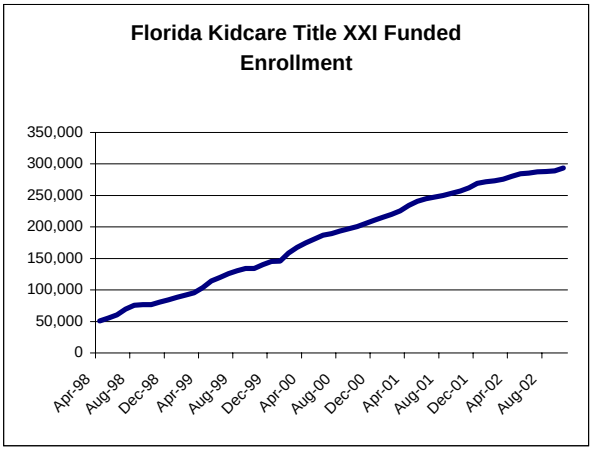
The CMS Network acts as a "wrap around" service – providing care to children in any of the Kidcare eligibility categories who have serious health care problems.

Medikids uses the Medicaid infrastructure, offering the same provider choices and basket of benefits. Healthy Kids contracts with its own managed care plans throughout the state, as does Children's Medical Services. All applicants for Florida Kidcare complete one simplified application. Pursuant to federal law, each application is screened for eligibility for Title XIX Medicaid. If eligible, the applicant is enrolled immediately into that program. If not eligible, the child's application is processed for Title XXI and, if eligible, the child is enrolled into the appropriate component.



Source: Agency for Health Care Administration

With the exception of the Medicaid component, the Florida Kidcare program is not an entitlement.



Source: Agency for Health Care Administration

METHODOLOGY

In conducting this review, staff interviewed stakeholders in the Kidcare program, agency staff and members of provider groups. Staff also reviewed state and national literature regarding Title XXI as well as evaluation and statistical reports about the Florida Kidcare program.

FINDINGS

Implementation Process

Like most states, Florida implemented its Title XXI program incrementally. An initial Child Health Plan (Title XXI) was submitted to the Federal Department of Health and Human Services in December of 1997, and included a conversion of Healthy Kids to Title XXI funding, expansion of Healthy Kids to additional counties with higher statewide enrollment levels, and an extension of Medicaid coverage to certain children. In July 1998, coverage was expanded to include children up to 200 percent FPL for: Medikids, ages 0 up to 5; the Healthy Kids program, ages 5-19; and the CMS Network for children who have special physical, developmental, or behavioral health care needs. A significant early hurdle in implementing Kidcare was the conversion of 50,000 prior-year Healthy Kids program enrollees to Kidcare coverage and screening these individuals for Title XXI or Medicaid eligibility. Infants up to age 1 were moved into coverage under the Medicaid program during the 2000 legislative session.

As noted earlier, Kidcare is an umbrella program, which encompasses the operations of four separate agencies, each of which has its own eligibility requirements in terms of age and income. There are additional eligibility standards applicable to children with special health care needs. Though the complexity of the program has at times proven to be challenging to participants and providers, overall, the program is meeting its goals of providing health care coverage to low-income children in a manner that maximizes draw-down of federal funds. Further, the results of customer satisfaction surveys indicate that 90 percent of participants in the program are satisfied or very satisfied with the program.

Another effect of the program, which has been reflected in participant comments, is that low-income parents are pleased with the ability to enroll their children in a health insurance program, since they believe that children without health insurance are treated like second-class citizens. Parents have cited cost as the primary barrier to obtaining traditional coverage, and indicate that the presence of an insurance product that is easy to obtain, is affordable, and provides ready access to quality medical care is perceived positively.

The downside of the program design of Florida Kidcare is that Florida has a complex administrative system. The financial eligibility requirements that differentiate whether an applicant ends up in Healthy Kids, Medikids, or Medicaid vary depending on age. In addition, since components have different service delivery models, a participant may be mandated to join an HMO, or may be allowed to choose between an HMO or a fee-for-service delivery system. If the applicant is a child with special health care needs, he or she will enter an entirely different service delivery system through the CMS Network. Depending on the component in which an individual is enrolled, he or she may be charged a premium, and may pay some deductibles.

As Florida has moved to full statewide implementation of the Kidcare program, there have been two areas of the program that have been the source of considerable controversy: local match requirements in the Healthy Kids component of Kidcare and the absence of a single agency controlling Kidcare operations.

Local Match

Healthy Kids is the largest non-Medicaid component of Kidcare, and pre-dates the Federal Title XXI program. Healthy Kids operates with a combination of local, state, and federal dollars, and family contributions. Prior to the enactment of Title XXI, counties in which the program operated were required to develop a plan to gradually increase county matching contributions from a base amount of five percent of total program costs, with a goal of eventually funding local program operations 100 percent from local funds.

Under early Healthy Kids program requirements, local matching funds could be obtained from any source: local tax dollars, health care providers who had traditionally provided charity care to indigent individuals, charitable contributions and other sources. In the original implementation of the program in the early 1990s, traditional providers of indigent care, particularly hospitals, often contributed local match using funds that had traditionally supported the provision of care to indigent children, since providing these children with health care coverage and the ability to secure regular preventive care was both a more economical and a more humane way to meet these children's health care needs.

At the time of implementation of Florida's Title XXI expansion of Healthy Kids, approximately $7,000,000 in local matching funds were committed to the program. With the advent of Title XXI, the Florida Healthy Kids Corporation could no longer accept provider funds for use as state match to cover children. Beginning in April, 1998, the corporation began asking counties to certify that local match contained no

provider funds. In October, 1999, Florida received confirmation from the Health Care Financing Administration indicating that rules pertaining to the source of match applicable to Medicaid also applied to Kidcare, meaning that funds received from providers of health care or related entities could not be used as match for Title XXI purposes. In January, 2000, the corporation began auditing local contributions to document that local matching commitments were not provider-related donations.

Enforcement of this provision caused considerable difficulty for local governments, both for those that had previously relied on provider funds to meet local match commitments, and those that had high demand for Kidcare slots and no ability to raise local taxes to support the match required to enroll children above base slots.

The 2001 Legislature, in proviso in the 2001 General Appropriations Act, replaced existing local match from surpluses within the Healthy Kids Corporation budget. In 2002, the Legislature replaced the requirement for local match with a policy that allows communities to, on a voluntary basis, use local funds , without regard to the source of funds, to support the enrollment of children who were are not eligible for federal Title XXI matching funds.

Kidcare Administration

The second area of difficulty has been the result of the operations of the Kidcare program being the responsibility of three state agencies and a public-private corporation. The statutory functions of these entities are as follows:

The Agency for Health Care Administration is designated the lead agency for Title XXI for purposes of receiving federal funds, for reporting purposes, and for ensuring compliance with state and federal regulations and rules. The agency directly administers the Medicaid and Medikids components of Kidcare.

The Department of Health is responsible for designing the eligibility intake system, designing and implementing program outreach activities, and chairing a state-level coordinating council to review and make recommendations concerning the implementation and operation of the program. The Department of Health is also responsible for the operation of the CMS Network of service providers for children with complex health problems in Kidcare.

The Department of Children and Families (DCF) is responsible for maintaining the eligibility determination process for the program, with the exception of the Healthy Kids program component.

The Healthy Kids Corporation contracts with private insurers for coverage for children not in the Medicaid or Medikids program, and collects premiums for children. The Healthy Kids Corporation fiscal agent screens all Kidcare applications, and forwards applications which appear to be for Medicaid-eligible children to DCF for eligibility determination for that program. Healthy Kids operates the hotline which citizens can call for information about the program, the status of their application or the status of their account.

The Kidcare Coordinating Council is charged with responsibility for making recommendations concerning the implementation and operation of the program. The council is chaired by the Secretary of the Department of Health, and is staffed by the Lawton and Rhea Chiles center for Healthy Mothers and Healthy Babies. Council members are appointed by the Secretary, and represent the Department of Health, the Agency for Health Care Administration, insurers, provider groups, academics, and representatives of advocacy groups.

Since the inception of the program, the agencies that operate Kidcare have made continual efforts to smooth the flow of applications through and between their programs in an effort to reduce the time it takes to process an application and to enroll eligible children in the appropriate program component. Ensuring compliance with federal and state law regarding placement of a child in the appropriate program component, and efficient use of state funds requires that a child's initial application and subsequent updates of that information be screened by state agencies. The agencies screen each application to either rule out or confirm eligibility factors that would render the applicant ineligible for the program entirely (such as being the dependant of a state employee) or suggest that an applicant might be eligible for one of the Kidcare program components (such as a child with special health care needs who should be enrolled in the CMS Network).

In late 2001, in response to criticism that the Kidcare programmatic and administrative structures were causing difficulties for families applying for entrance into the system and transitioning between components in the system, the Healthy Kids Corporation contracted with Maximus Incorporated to perform a review of the Kidcare eligibility determination process to identify

changes that could improve system functioning. Maximus performed its analysis in the context of three goals:

- Reduce the time it takes to process an application and enroll an eligible child into Kidcare;
- Facilitate enrollment of children in the correct Kidcare program; and
- Reduce the chances of a break in coverage for a child who is moving from Medicaid to a non-Medicaid Kidcare component.

Maximus developed 28 recommendations specific to these goals, grouped into those that could be implemented with relatively little lead time or planning, those that would require six to eight months to implement, and long-term recommendations that would take considerable time and effort to implement. The recommendations were presented to the Healthy Kids Corporation Board of Directors and the Kidcare Coordinating Council in April and June 2002.

Recommendations that could be implemented with little lead time included modifying the tool used by the Healthy Kids Corporation to pre-screen for likely Medicaid eligibility to reduce "false positives" requiring extra processing by DCF; changing the point in the eligibility cycle at which applications are matched against the state employee database (by federal law state employees are ineligible for Title XXI funded services); modifying the renewal notice to allow families to provide health status and immigration information about children in the program; maintaining continuous eligibility for families reporting a downward change in income; and providing for electronic transmission of certain information between the agencies and the Healthy Kids Corporation.

Recommendations that were estimated to require six to eight months to implement included modifying the monthly process of matching new applicants against existing Medicaid recipients; developing an automated referral process for children who are being dropped from Medicaid to facilitate their enrollment into an appropriate Kidcare component to eliminate gaps in coverage; soliciting missing information by phone rather than by letter; improving the automated link between the Healthy Kids Corporation fiscal agent and the CMS Network; making a number of changes to the Kidcare application form to facilitate proper eligibility determination and placement in the appropriate Kidcare component; developing an online Kidcare application; and modifying the DCF business process regarding the flow of applications between local offices and the Kidcare central processing unit.

Longer-term recommendations included creating an automated data interface between the DCF FLORIDA system and the Healthy Kids Corporation third-party administrator to eliminate duplication of effort and reduce the risk of data entry errors; permitting the Healthy Kids Corporation third-party administrator to make Medicaid eligibility determinations subject to DCF approval; re-engineering the Medicaid redetermination process to eliminate the requirement for a new application on a periodic basis and allow a simpler means for families to update their eligibility information; and requiring the Healthy Kids Corporation fiscal agent to process applications in Florida rather, than in Illinois.

In addition Maximus recommended that the state increase the security of data transmissions between Kidcare entities and align Medicaid and Title XXI eligibility rules; modify the system by which correspondence is generated by the Healthy Kids Corporation fiscal agent in order to prevent families from receiving multiple letters requesting missing information; modify certain processing dates to align functions of Medikids, Healthy Kids, and CMS; establish a data link between the CMS and DCF FLORIDA data systems; evaluate using optical character readers for data entry; and improve collaboration among Kidcare entities.

Maximus conducted the study in a collaborative fashion by soliciting input from a wide variety of Kidcare stakeholders. The approach to identifying processes that caused programmatic difficulties, then building consensus and buy-in for development of solutions among the Kidcare entities resulted in general acceptance of the proposals developed in the study.

Staff of the Kidcare entities began planning soon after the report was issued, and further sorted the recommendations in terms of those that could be accomplished at little or no cost to the program. Subsequently a work plan was developed from which flowed a series of activities to implement the recommendations.

As of December 1, 2002, many of the short-term recommendations have been implemented, including: modifying the monthly process of matching new

applicants against existing Medicaid recipients; changing the system of monthly data matches against Medicaid and state employee files; improving the Medikids data interchange; revising the passive renewal notice; instituting electronic submission of sibling data to DCF; using social security income to reduce false positives; enhancing the security of some interagency data interchanges; and reducing the number of letters families receive requesting missing information.

The Kidcare entities are conducting a pilot project to evaluate the effectiveness of synchronizing the Healthy Kids, Medikids, and CMS Network processing schedules. A new Kidcare application is scheduled to be implemented January 1, 2003, which will incorporate changes designed to allow more efficient collection of immigration information and information about non-applicant children. In addition, as of January 2003, the CMS Network eligibility process will be re-engineered and an automated referral process for children leaving Medicaid will be implemented.

Several recommendations are still being evaluated in terms of difficulty and cost, including processing all applications in Florida, re-engineering the Medicaid re-determination process, and authorizing the Healthy Kids fiscal agent to perform Medicaid eligibility determinations.

Creating a two-way automated data interface between Healthy Kids and DCF to reduce gaps in coverage for children transitioning between Kidcare programs has proven to be one of the most complex and expensive of the recommendations to implement. An analysis from DCF indicates that the cost to re-program the FLORIDA system to accept data from the Healthy Kids system is approximately $740,000. Exchanging information in the opposite direction, from the DCF FLORIDA system to the Healthy Kids system has a cost of approximately $87,000. This second, lower cost portion of the interface is currently being developed.

Other Administrative Issues: CHIP Dip and the Repeal of the Kidcare Act

Congress set aside approximately $40 billion over ten years for SCHIP programs. The Balanced Budget Act of 1997, which created SCHIP, reduced funding to states by 26 percent, or more than $1 billion, in federal fiscal year 2002 and is scheduled to remain at this level for each of the next two fiscal years. This reduction was in response to budget constraints rather than for policy reasons.

Because of these federal funding reductions (referred to as the "chip dip") and rising SCHIP enrollment, many states are expected to have insufficient funds to sustain their enrollment in future years. Accordingly, the Office of Management and Budget projects that national SCHIP enrollment will decline by 900,000 children over three years (between 2003 and 2006). While many states have unspent funds from prior years, these are not excess funds and are needed to fund states' increased enrollment in SCHIP, as well as to offset the effects of federal funding reductions. In many states, SCHIP expenditures will outpace the annual federal SCHIP allotment that the state receives. The Center on Budget and Policy Priorities projects that 35 states (including Florida) will receive lower 2003 SCHIP allocations than the federal share of their 2003 SCHIP expenditures.

Florida's Kidcare federal Title XXI expenditures are estimated to be $313.2 million in federal fiscal year 2003. Beginning in fiscal year 2002, Kidcare federal expenditures exceeded the federal year's allotment. Although federal expenditures for federal fiscal year 2002 exceeded the allotment, Florida had significant unspent prior year federal allotments leaving an unspent balance of $413.2 million. However, if current expenditure patterns continue, the Agency projects a deficit beginning in federal fiscal year 2005. This estimate basically holds expenditures constant and does not include any annualization of state fiscal year 2002-2003 appropriations. The Agency estimates this annualization to be $66.6 million ($17 million in state funds, $0.5 million in family premiums and $49.1 million in federal XXI funds) and is included in the Agency's Legislative Budget Request for state fiscal year 2003-2004.

Congress proposed, in the Children's Health Improvement and Protection Act of 2002 (S. 2860), to modify the rules for redistribution of unspent SCHIP funds and extend the availability of federal fiscal year 2000 and subsequent fiscal year allotments as well as restore funding for federal fiscal years 2003 and 2004. Congress went into recess without action on this bill.

Florida SCHIP Allotments, Expenditures and Cash Balances – Federal Fiscal Year

FFY	Beg Bal	SCHIP Allot	Allot Adj	Total Rev	Federal Expen	Cash Balance
1998		$270.2		$270.2	$6.4	$263.8
1999	$263.8	$268.9		$532.7	$51.0	$481.7
2000	$481.7	$242.1		$723.8	$125.7	$598.1
2001	$598.1	$220.2	($30.9)	$787.4	$195.2	$592.2
2002	$592.2	$164.2	($75.5)	$680.9	$267.7	$413.2
2003	$413.2	$172.0	($28.8)	$556.4	$313.2	$243.2
2004	$243.2	$167.4		$410.6	$313.2	$97.4
2005	$97.4	$215.2		$312.6	$313.2	($0.6)
2006	($0.6)	$215.2		$214.6	$313.2	($98.6)
2007	($98.6)	$265.6		$167.0	$313.2	($146.2)

* SCHIP allotments have been adjusted to reflect reductions for redistribution pool and supplemental grant awards.

Section 57 of the bill that created Kidcare (CS/HB 4415) provides for an automatic repeal of the Kidcare program, subject to legislative review, under certain circumstances:

> Sections 409.810 through 409.820, Florida Statutes, as created by this act, are repealed, subject to prior legislative review, on the first July 1 occurring at least 1 year after the effective date of an act of the United States Congress or the federal Health Care Financing Administration which:
>
> (1) Reduces Florida's federal matching rate under Title XXI of the Social Security Act to less than 65 percent federal match; or
>
> (2) Reduces the federal funds allotted to Florida under Title XXI of the Social Security Act to less than $250 million annually.

This provision was intended to protect Florida from a reduction in federal funds and the resulting deficit had the state been unable to control entrance into the program. However, state law in s. 409.813, F.S., clearly defines the Title XXI portions of Kidcare as a non-entitlement program. The entities operating the Kidcare program are required by s. 409.8134, F.S., to cease enrollment if insufficient funds are available to finance the program.

RECOMMENDATIONS

The entities that operate the Florida Kidcare program should continue their progress on implementation of the administrative improvements recommended in the Maximus study.

The Legislature should provide funding to develop an electronic data interface to allow the DCF FLORIDA system to accept data from the Healthy Kids Corporation fiscal agent.

The Legislature should remove the self repealer from the Florida Kidcare Act, since sufficient statutory authority is in place to manage enrollments in the program to prevent a deficit in state funds.