The Florida Senate

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Committee on Health Policy

THE FLORIDA KIDCARE PROGRAM: ORGANIZATIONAL STREAMLINING AND ADMINISTRATIVE SIMPLIFICATION

SUMMARY

The Florida KidCare program provides health care coverage to over 1.4 million children in Florida. KidCare is an "umbrella" program, the components of which include Medicaid for children, the Florida Healthy Kids program, Medikids, and the Children's Medical Services Network. Linking these components under this umbrella resulted in a complex administrative structure for the program, with different financial eligibility requirements, benefit designs, service delivery systems, cost sharing requirements, and multiple administrative entities.

This administrative structure has created barriers to access in the past, although many of these barriers have, or are currently, being addressed. This report recommends further incremental approaches for organizational streamlining and administrative simplification. A model for comprehensive reorganization is also provided for consideration.

BACKGROUND

The Florida KidCare program provides health care coverage to over 1.4 million children in Florida. KidCare is an "umbrella" program, the components of which include Medicaid for children, the Florida Healthy Kids program, Medikids, and the Children's Medical Services Network (CMSN). Family income level, age of the child, and whether the child has a serious health condition are the eligibility criteria that determine which component serves a particular child.

State Children's Health Insurance Program (SCHIP)
KidCare is Florida's program implementing the national State Children's Health Insurance Program (SCHIP or Title XXI of the Social Security Act). The goal of SCHIP is to expand health coverage to children whose families' incomes are too high for the children to be eligible for Medicaid (Title XIX of the Social Security Act), but too low for the families to afford private coverage for their children.

Similar to Medicaid, SCHIP provides each state the flexibility to design its program within broad federal guidelines and to modify aspects such as eligibility standards, benefit designs, and limited cost sharing requirements (premiums, deductibles, and co-insurance). However, unlike Medicaid, SCHIP is not an entitlement program and there are limits to the amount of money the federal government has allocated to each state through federal matching funds, known as the annual federal allotment. Also, the federal match rate differs between Medicaid and SCHIP, with SCHIP providing a higher federal match rate.[1]

SCHIP is designed to provide coverage to "targeted low-income children." A "targeted low-income child" is one who resides in a family with income below 200 percent of the Federal Poverty Level (FPL) or whose family has income up to 50 percent higher than the state's Medicaid eligibility threshold.[2]

Because of the program's flexibility, some states have expanded SCHIP eligibility beyond the 200 percent FPL limit, and others are covering entire families and not just children. As of July 2006, thirty-four states and the District of Columbia have eligibility levels up to and including 200 percent of the FPL. An additional fourteen states cover children with family income up to and including 300 percent of the FPL, and one state

[1] For FY 2006-07, Florida's Medicaid federal match rate is 58.76 percent and SCHIP is 71.13 percent.
[2] The Federal Poverty Level is set at $20,000 for a family of four in 2006.

(New Jersey) offers SCHIP coverage to children up to 350 percent of the FPL.[3]

Title XXI provides states with three main options when designing their SCHIP program. First, eleven states and the District of Columbia chose to expand Medicaid eligibility to children who previously did not qualify for Medicaid coverage. Second, eighteen states designed a children's health insurance program entirely separate from Medicaid. And third, twenty-one states combined Medicaid expansions and separate program options.

States that choose the Medicaid expansion option must provide coverage under SCHIP that mirrors the Medicaid coverage provided by that state in its State Medicaid Plan. States that opt to have a separate SCHIP program have four different options for structuring their benefit package: benchmark coverage, benchmark equivalent coverage, Secretary of Health and Human Services-approved coverage, and existing state-based comprehensive coverage. Florida was one of three states (New York and Pennsylvania are the others) "grandfathered in" to use existing state-based comprehensive coverage (Florida Healthy Kids coverage).

The Florida KidCare Program

The Florida KidCare program was established in 1998 as a combination of Medicaid expansions and public/private partnerships, with a wrap-around delivery system serving children with special health care needs. When the KidCare program was established, this structure allowed the state to link existing public and private programs to implement provisions of the new SCHIP law and to begin receiving federal funds under Title XXI.

However, the choice of using existing state-based comprehensive coverage resulted in a complex administrative structure for the program with different financial eligibility requirements that vary by age, benefit designs that vary among program components, different service delivery systems ranging from fee-for-service to mandatory health maintenance organization (HMO) enrollment, different cost sharing requirements, and multiple administrative entities over each component. More specifically, the components of the Florida KidCare program consist of the following:[4]

Medicaid[5] – for children who qualify for Title XIX under the following income limits: ages 0 to 1 up to 200 percent of the FPL (infants between 185 percent and 200 percent of the FPL are actually financed by Title XXI funds); ages 1 to 5 up to 133 percent of the FPL; and ages 6 to 19 up to 100 percent of the FPL.

Medicaid benefits are specified in statute (ss. 409.905 and 409.906, F.S.) and must include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Depending on geographic location, a child may receive Medicaid services through either a fee-for-service delivery system or a managed care plan. There are no premiums, deductibles, or co-insurance requirements for children in Medicaid. Medicaid eligibility is determined by the Department of Children and Families Services (DCF) and the program is administered by the Agency for Health Care Administration (AHCA). As of September 2006, 1,210,988 children were enrolled in the Medicaid program component of KidCare (1,177 of these children were funded by Title XXI).

Medikids[6] - for children ages 1 through 4 who are not Medicaid eligible with family income between 134 percent and 200 percent of the FPL. This component is financed by Title XXI funds.

The Medikids benefit package mirrors the Medicaid benefits as prescribed by statute, including Medicaid children's dental benefits, except for Medicaid waiver services. Depending on geographic location, a child may receive Medikids services through either a fee-for-service delivery system or a managed care plan. Families with incomes between 134 percent and 150 percent of the FPL pay a $15 monthly premium and families with incomes between 151 percent and 200 percent of the FPL pay a $20 monthly premium. The premium is per family no matter how many children are enrolled. Families with income above 200 percent of the FPL may enroll their children in Medikids, but are required to pay the full cost of the premium for each child ($159 per month per child). These children are known as "full pays." By law, the number of full-pay children in Medikids may not exceed 10 percent of total enrollees in the Medikids

[3] Tennessee provides coverage to children above the Medicaid state plan level under an 1115 Research and Demonstration Waiver that does not have a specific upper income eligibility limit.

[4] The Florida KidCare program is authorized in ss. 409.810 through 409.821, F.S.

[5] Sections 409.901-409.920, F.S.

[6] Section 409.8132, F.S.

program in order to reduce the risk of adverse selection. There are no other cost sharing requirements. Medikids eligibility is determined by the Florida Healthy Kids Corporation. The corporation also collects premiums for Medikids and transfers these funds to AHCA. All other aspects of the program are administered by AHCA. As of September 2006, 19,038 children were enrolled in the subsidized Medikids component and another 59 children were full-pay enrollees.

Florida Healthy Kids[7] – for children ages 5 up to 19 who qualify for Title XXI up to 200 percent of the FPL. The Florida Healthy Kids program also covers two other groups of children who do not qualify for federal Title XXI funding: 1) children who meet Title XXI income eligibility but do not qualify based on other eligibility requirements (e.g., children of state public employees, certain qualified aliens); and 2) children in families with income above 200 percent of the FPL who pay full premiums. By law, the number of full-pay children in Florida Healthy Kids may not exceed 10 percent of total enrollees in the Florida Healthy Kids program in order to reduce the risk of adverse selection.

Florida Healthy Kids offers comprehensive health benefits, including dental coverage, that meets most children's needs. Families also have the option of choosing only medical coverage for a lower premium if they are full pay. Children in Florida Healthy Kids receive services through managed care organizations. Families with incomes up to 150 percent of the FPL pay a $15 monthly premium and families with incomes between 151 percent and 200 percent of the FPL pay a $20 monthly premium. The premium is per family no matter how many children are enrolled. Families with income above 200 percent of the FPL are required to pay the full cost of the premium for each child ($120 per month per child for medical and dental coverage or $108 per month per child for medical only). There are some co-payments required in Florida Healthy Kids, usually ranging between $5 and $10 for some services and prescriptions. Florida Healthy Kids eligibility is determined by the Florida Healthy Kids Corporation through its fiscal agent. All applications processed through the corporation receive an initial screening for Medicaid eligibility and those persons assumed to be Medicaid eligible are referred to DCF. The Florida Healthy Kids Corporation administers the program under contract with AHCA. As of September 2006, 167,804 children were enrolled in the subsidized component of Florida Healthy Kids and another 26,640 were enrolled as non-Title XXI (full pay).

Children's Medical Services Network (CMSN)[8] - for children ages 0-19 with special health care needs whose family income is up to 200 percent of the FPL. The network also includes a behavioral health program. CMSN is financed through Title XIX (Medicaid), Title XXI (SCHIP), and some state funds for its "safety net" component.

Children enrolled in CMSN receive the Medicaid benefit package, including dental services, but not Medicaid waiver services. Eligible school age children with serious emotional disturbances or substance abuse problems who are enrolled in DCF's Behavioral Health Network (BNet) are enrolled in CMSN for their physical health care. Children enrolled in CMSN receive care through a network of approved providers or integrated care service networks (essentially provider-based managed care organizations). For children in CMSN who are financed through Title XXI, families with incomes up to 150 percent of the FPL pay a $15 monthly premium and families with incomes between 151 percent and 200 percent of the FPL pay a $20 monthly premium. The premium is per family no matter how many children are enrolled. There are no co-payment requirements for children in CMSN who are financed by Title XIX or Title XXI. CMSN financial eligibility is determined by either DCF or the Florida Healthy Kids Corporation and medical eligibility is determined by the Department of Health (DOH) or DCF if a behavioral condition is present. CMSN is administered by DOH. The Florida Healthy Kids Corporation collects premiums for Title XXI eligible children. As of September 2006, 10,012 children were enrolled in the Title XXI subsidized component of CMSN.

METHODOLOGY

In conducting this review, staff interviewed stakeholders in the Florida KidCare program, agency and department principals, members of provider and advocacy groups, Florida Healthy Kids Corporation board members, and SCHIP policy experts. Staff also reviewed state and national literature regarding Title XXI, as well as evaluation and statistical reports about the Florida KidCare program. Data were provided by and full cooperation was extended from the Florida Healthy Kids Corporation, DCF, AHCA,

[7] Section 624.91, F.S.

[8] Part 1, ch. 391, F.S.

DOH, and various stakeholders. Senate staff analyzed the major functions of the Florida KidCare program to determine where problems still exist and how these problems could be addressed.

FINDINGS

Advocates and some stakeholders have long argued that KidCare's administrative structures and programmatic differences create barriers to the enrollment of eligible children in the program. These groups point to the recent decline in KidCare enrollment as a strong example of how substantive policy changes and on-going administrative barriers prevent eligible children from entering and remaining in the program. Specifically, stakeholders point to the decline in Title XXI enrollment from a high of 336,689 children in April 2004 to a low of 186,080 children in February 2006 as an indication of policy and administrative barriers. These barriers are deemed so significant that one of the primary recommendations of the KidCare Coordinating Council is to "create a single administration for marketing, eligibility, contracting, quality assurance, and financing" that would address these issues.

However, others argue that while administrative structures are probably more complex than necessary, most problems created by these barriers have been corrected over the years and any remaining issues are being addressed. These stakeholders point to the eligibility determination study conducted by MAXIMUS, Inc., in 2002, which made twenty-eight recommendations pertaining to the following:[9]

- **Timeliness** – reduce the time it takes to process an application and enroll an eligible child.
- **Program fit** – facilitate enrollment in the right program.
- **Gap in coverage** – reduce the chances of a break in coverage for a child who is moving from Medicaid to a non-Medicaid Title XXI program.

The MAXIMUS study's recommendations were adopted by the Florida Healthy Kids Corporation and program changes were implemented over the next four years. As of September 2006, only seven of the twenty-eight recommendations have not been completed. Of the uncompleted recommendations, most will not be implemented because they involve information technology changes that cannot be incorporated into the current information systems. While it appears that the issues in the MAXIMUS study have been addressed, the question remains whether there are still administrative barriers that prevent or deter eligible families from entering and remaining in the Florida KidCare program.

KidCare Marketing and Outreach

The Florida KidCare program has tried multiple approaches to educating families about the existence of the program and how to enroll their children. Originally, outreach activities were coordinated and administered through DOH. Outreach activities constituted outreach coordinators in local communities who worked through schools, health departments, eligibility offices, and other locations to educate families about the availability of the program and how to apply. These workers also distributed applications in the community.

In July 2003, federal and state funding for KidCare outreach was eliminated over concerns that increases in enrollment would cause Florida to exceed its federal SCHIP allotment. Between 2003 and 2006, most activities conducted to educate families about KidCare were social marketing campaigns administered by the Florida Healthy Kids Corporation. These social marketing campaigns educated families about the availability of the program, open enrollment periods, and changes to the application process. In 2006, the Florida Legislature appropriated $1 million of non-recurring general revenue funds to the Florida Healthy Kids Corporation for a KidCare community-based marketing and outreach matching grant program. The Florida Healthy Kids Corporation awarded the first round of outreach grants to community organizations in September 2006, with a second round of grants to be awarded in October 2006.

Because most families report they learn about KidCare through word of mouth,[10] many stakeholders argue that changing policies and administrative processes create the most significant barriers to successful marketing

[9] July 2002. *Florida KidCare Eligibility Determination Study*. Report to the Florida Healthy Kids Corporation Board of Directors. http://www.healthykids.org/documents/evaluation/other/maximus_200208p3r.pdf (last visited on September 28, 2006).

[10] *Florida KidCare Program Evaluation Report, 2004*. Institute for Child Health Policy, University of Florida. Pages 40-41. Found at: http://www.ichp.edu/documents/KidCareEvaluationYear6_2004Data_FinalReport_06202005.pdf (last visited on September 28, 2006).

and outreach. For example, most stakeholders report that there is still confusion around the state over whether the Florida KidCare program is open for new enrollment (the state reopened year round enrollment in June 2005). Many stakeholders believe that maintaining stability in the program will have the most significant effect on facilitating enrollment and retention.

Some stakeholders believe that educating the public with general program information should be the main focus of any marketing and outreach activities. Others believe that the program needs a much more intensive type of outreach activity where families are directly engaged in the community and provided personal assistance in completing the application process and encouragement to continue enrollment. Still others argue that the marketing and outreach activities should provide broader education, including the value of obtaining and continuing health coverage for them and their children.

Several stakeholders recommended ways to improve the marketing and outreach activities. First, the state could continue or increase funding for marketing and outreach activities, regardless of the type of activities or which administrative entity has responsibility for the activities. Second, the state could re-establish the outreach model that was used in the early years of the program and house the effort under a single administrative entity. Third, the state could allow the current managed care plans to provide marketing and outreach activities, with appropriate restrictions to prevent unfair trade practices. Some stakeholders argue that all of these models could be supported and that the important factor was simply having marketing and outreach programs.

Regardless of which model is used, important factors to be considered in deciding which activities should be supported include a clear understanding of the goal of the marketing/outreach activities (e.g., an increased number of applications, increased enrollment, general brand identification, etc.) and how to measure whether the marketing/outreach activities have accomplished the goal (i.e., the return on investment).

Enrollment and Eligibility Determination Process

In FY 2004-05, only 52 percent of all children who applied for KidCare coverage were eventually enrolled in any of the four KidCare program components. This completion rate was down from 69 percent in FY 2003-04 and 82 percent in FY 2002-03.[11] Furthermore, between January and July 2006, only 30 percent of families enrolled in the program had applications that were complete (that is, included all documentation necessary for eligibility determination) at the initial submission of the KidCare application.

Stakeholders point to these figures and their personal interactions with families to argue that KidCare's administrative structures still create barriers in the enrollment and eligibility determination process. This is the case even though these program functions have received the most attention and modifications over the years. Because these reported barriers generated the broadest concern among stakeholders, enrollment and eligibility determination issues were assessed in this interim project to determine the following:

- Are there still administrative factors that deter families from applying for KidCare?
- Do current administrative structures discourage families from completing the application process?
- Are there currently administrative factors that complicate the eligibility determination process?

A family applying for the Florida KidCare program may have to go through as few as one, or as many as four, administrative entities to enroll a child in the program. Because each component's eligibility criteria vary by income and age, a family enrolling multiple children may have to meet different standards for each child and provide different documentation for each child to determine eligibility.

There are two main ways that families apply for KidCare: 1) through DCF's Economic Self-Sufficiency (ESS) application process; or 2) directly applying through Florida Healthy Kids. If the application comes through DCF, it is reviewed for Medicaid eligibility. If the child is not Medicaid-eligible, the application is forwarded to Florida Healthy Kids for Title XXI processing. On the other hand, if the application first comes through Florida Healthy Kids, the corporation's fiscal agent makes an initial assessment of whether the child appears to be Medicaid-eligible (federal law prohibits Title XXI funds being spent on a Medicaid-eligible child). If the child does not appear to be Medicaid-eligible, then the corporation immediately processes the application for Title XXI eligibility. However, if the child appears to be Medicaid-eligible,

[11] *Florida KidCare Program Evaluation Report, 2005*. Institute for Child Health Policy, University of Florida. Page 24.

the application is transferred to DCF for processing. In this case, if DCF determines the child is not eligible for Medicaid, the application is referred back to Florida Healthy Kids for Title XXI eligibility determination. If, during either process, information is provided that indicates a child may have special health care needs, the application is referred to DOH for a medical determination of eligibility for CMSN.

Stakeholders point to this back and forth transferring of applications as one of the main barriers in the application process. They also point to problems with documentation being lost during transfers or the inability to link documents with the primary application (known as orphan documents). Many reported they believe DCF and Florida Healthy Kids are losing documents and that families are unable to obtain reliable information about where their application is in the eligibility determination process. Stakeholders also report that this process generates a large amount of correspondence between families and program administrators that can be confusing and contradictory. Finally, they point to differences in eligibility determination documentation requirements as a significant barrier to enrollment.

However, these concerns appear to be problems that occurred in the past that have largely been eliminated by process improvements over the last year. Specifically, all applications, and their accompanying documentation, are immediately scanned into digital files upon receipt. This has virtually eliminated the transfer of paper between DCF and Florida Healthy Kids. When electronic information is transferred from Florida Healthy Kids to DCF, all necessary data fields in the online application are automatically populated to speed the application process. The same will be true when data is transferred from DCF to Florida Healthy Kids after new system updates are implemented in November 2006.

Regarding orphan documents, this only appears to have been a significant problem during the single open enrollment period that occurred in January 2005. With year round open enrollment, there is no evidence this is still occurring with any frequency. Also, families are now able to go online to track where their application is in the eligibility determination process, whether their children are active in the program, and the ongoing status of their account.

The issue of the amount of correspondence is also being addressed. The Florida Healthy Kids Corporation worked with the Covering Kids Campaign out of the University of South Florida to review all KidCare correspondence for clarity and necessity. Changes have been made to the letters being sent to families, although there are limits to modifications due to legal requirements. Currently, a typical family applying for Florida Healthy Kids receives an average of five letters during the eligibility determination process. The most frequently sent correspondence includes: 1) a receipt of application letter; 2) a request for missing information; 3) a notification that the application has been referred to DCF for Medicaid eligibility determination; 4) an approval or denial letter; and 5) a notification of missing premium payments. All of these seem appropriate and necessary.

The final issue of different eligibility determination documentation requirements is probably the most controversial and most often cited barrier in the enrollment process. A review of the process does indicate significant differences between Medicaid Title XIX eligibility determination and Florida Healthy Kids Title XXI eligibility determination.

For Medicaid eligibility determination, a family must self-declare their monthly income on the application. The parents', or custodians', social security numbers are submitted to three electronic databases for income verification purposes.[12] If social security numbers are not provided (a minority of applications) then recent pay stubs or an employer income verification form is required (providing parental or custodial social security numbers is optional if the application is only for services for the child). While awaiting the data match for income verification, DCF verifies an applicant's birth certificate information and their identity as required by the new federal Deficit Reduction Act (DRA). As long as an applicant's reported income is not substantially different than the information obtained through the data match, and the income is below the eligibility threshold, the child is enrolled in Medicaid. For the majority of children on Medicaid, it is only at a child's eligibility redetermination period, usually twelve months after enrollment, that pay stubs and other income verification documentation are required for the first time.

For Florida Healthy Kids Title XXI, the income eligibility determination process requires more documentation. Before being enrolled in Title XXI, a family must provide written documentation during the

[12] These databases verify Social Security Income; Internal Revenue Service reported income, and wages reported to the state.

initial application process, and the redetermination process, including, but not limited to, proof of family income, which must include a copy of the applicant's most recent federal income tax return. In the absence of a federal income tax return, an applicant may submit wages and earnings statements (pay stubs), W-2 forms, or other appropriate documents. The family must also provide a statement from all family members that their employer does not sponsor a health benefit plan for employees; or the potential enrollee is not covered by the employer-sponsored health benefit plan because the potential enrollee is not eligible for coverage, or, if the potential enrollee is eligible but not covered, a statement of the cost to enroll the potential enrollee in the employer-sponsored health benefit plan.[13]

Stakeholders argue that the Florida Healthy Kids documentation requirements deter families from completing the application process, which may ultimately create adverse selection against the program because only families with children with known medical needs have the incentive to complete the process. Others argue that these income documentation requirements are a reasonable approach to ensure that only eligible children are enrolled in a program with finite federal matching funds.

Transitioning and Retention

Between January and June 2006, DCF referred 42,994 children to Florida Healthy Kids who had lost Medicaid eligibility because they exceeded either the income or age thresholds for the program. Most of these children (39,355 or 91.5 percent) were already in the Florida Healthy Kids information system. Of those previously known to Florida Healthy Kids, 16,168 (41 percent) were approved for Title XXI enrollment. Stakeholders point to this drop in enrollment as children transition from Medicaid to Florida Healthy Kids as another example of how policy and administrative structures create barriers in KidCare.

Most stakeholders attribute this drop during transition to the same problems in the eligibility determination process that have already been discussed. Others ask whether the difference between the Medicaid and Florida Healthy Kids financial eligibility determination processes is allowing some children into the Medicaid program who may actually be exceeding both the Medicaid and Florida Healthy Kids income limits. Since Medicaid's initial eligibility determination process is based on self-declaration and is less document-driven than at a child's redetermination, usually twelve months after enrollment, it may be that the children are unable to transition simply for lack of financial eligibility. However, since a family's income may fluctuate significantly during the year and the income verification processes only reflect a specific timeframe, data is not available to determine whether these children would have been eligible from the outset if they were required to go through the more stringent Florida Healthy Kids eligibility determination process. Still other stakeholders say that price sensitivity is the main factor and that families who paid no premiums in Medicaid are unable or unwilling to pay the $15 or $20 Florida Healthy Kids premium required at transitioning.

While the reasons behind the loss of children when transitioning from Medicaid to Florida Healthy Kids is debatable, most stakeholders do agree that there is a gap in coverage between when a child loses Medicaid eligibility and is enrolled in Florida Healthy Kids. The most common cause explaining this delay is the inability to enroll children in Florida Healthy Kids until their application has been completed and their premium is received.

To address this gap, some have argued that KidCare should institute presumptive eligibility where a child is enrolled upon receipt of an application and then only removed from the program if documentation ultimately demonstrates that the child is not eligible. Others have suggested that Medicaid HMOs, which often have a companion Florida Healthy Kids plan, should be provided notice when a child in their plan is losing Medicaid eligibility so they can conduct outreach to the family to speed the application process. Still others have suggested the state seek a Medicaid waiver to expand Medicaid eligibility for a limited period of time to allow continuous coverage while a family completes the Florida Healthy Kids application process.

Program Administration and Oversight

The current KidCare administrative structure is specified in statute, with the various principals responsible for specific program functions. As discussed, this structure was the result of the state using existing programs to implement the SCHIP law. Almost ten years after KidCare's creation, some argue that this structure is no longer viable and can be simplified. These stakeholders state that the program would be more efficient and there would be greater accountability by consolidating as many functions as possible under as few administrative entities as possible. Others state that most problems have been addressed and that the various entities bring unique

[13] Section 409.814(8), F.S.

skills to the administration of the program. They also argue that any consolidation would cause unnecessary confusion in the eyes of the public, resulting in instability and drops in enrollment just as enrollment trends are beginning to move upward. What most stakeholders do agree with is that there is no clear "leader" for the KidCare program and that there are times where the various administrative entities act in their own interest, rather than the interest of the program as a whole.

One of the most often cited examples of this lack of accountability is the absence of administrative rules adopted for the KidCare program since its creation in 1998. Section 409.818, F.S., clearly specifies KidCare rulemaking responsibilities for DCF, DOH, and AHCA, however, there have been almost no rules adopted over the years. The only rules adopted have been limited to some DCF eligibility determination processes and multiple cross references in various administrative definitions. Stakeholders argue that rules must be adopted for the entire KidCare program, especially to clarify the policy authority governing the Florida Healthy Kids Corporation and its activities.

Options for Streamlining and Simplification

Whether to consolidate or retain the current administrative structure has been debated for several years. Restructuring has certain advantages and disadvantages; however, it is uncertain whether major restructuring would solve remaining issues. For this reason, there are two possible alternatives for administrative simplification and organizational streamlining: continuation or consolidation.

Continuation

The first alternative is to continue the incremental approach to improving administrative functions. This would include: continuing or expanding financing of marketing and outreach activities; allowing new partners to conduct marketing and outreach; requiring the same information to be submitted by all applicants regardless of the KidCare component for which the child is eligible; reducing or eliminating the gap in coverage when children transition between components (including early outreach to families losing Medicaid coverage and applying for a waiver, if necessary, to continue Medicaid coverage for a limited period of time while the KidCare application is being completed); and identifying policies and program activities that require the adoption of administrative rules and requiring rule promulgation by each principal.

Most stakeholders also identified the Medikids program component as an area where administrative simplification could be accomplished. They point out that the program component has the same benefits as Medicaid for children and is already administered by AHCA. The only differences are that Medikids is funded by Title XXI (thus is not an entitlement) and eligibility determination and premium collection are conducted by the Florida Healthy Kids Corporation. Medikids could be administered completely within the Medicaid program, which would mean that families would no longer be required to pay a premium and it would effectively change this component to a Medicaid expansion and would require a state plan amendment. The other option would be to roll the program into Florida Healthy Kids, although this would reduce the set of benefits for these children, may limit their provider network, and would require the Florida Healthy Kids Corporation to modify its contracts with its health plans. It would also likely affect Florida Healthy Kids capitation rates.

The advantages to the approach of continued incremental improvements in KidCare's existing administrative structures are minimal disruptions in the current program, lower implementing costs, and more accountability. The disadvantages of this alternative are missed opportunities for efficiencies, continued confusion over who ultimately has leadership for the KidCare program, and the transitioning of Medikids into an entitlement program.

Comprehensive Consolidation

The second alternative is to consolidate KidCare marketing, eligibility, contracting, quality assurance, and financing under a single administrative entity. The end goal of the comprehensive consolidation would be to create a seamless KidCare program where the distinction of which component is serving a particular child is transparent to the child, the family, and health care providers. Families would be told that their children will receive KidCare coverage, although some documentation will be necessary to see if the child is eligible for subsidies to reduce, or eliminate, their monthly premium.

Under this model, there would only be a single KidCare application. Families would be required to submit all the information required to determine eligibility for all KidCare components to DCF. Medicaid (Title XIX) and SCHIP (Title XXI) policies for eligibility and documentation requirements for income verification would be aligned to the extent allowed by federal law or waivers. All correspondence

with the family would come from a single entity called KidCare.

Once children are deemed eligible, they would be referred to AHCA who would enroll the children in KidCare health plans under contract with the agency. Families would be allowed to choose among KidCare health plans in their county. A child's program eligibility would be transparent to the health plan and only AHCA and DCF would be aware if the child is covered by Medicaid or SCHIP. Even families would no longer know whether their child is on Medicaid or SCHIP.

KidCare plans would offer two health benefit packages: a standard package that provides most children with most services and a "KidCare Plus" package for children with special health needs. This would require the current Florida Healthy Kids benefit package to be expanded to the same level as the current Medicaid benefit package for children (federal law would prohibit using the current Healthy Kids benefit package for Title XIX eligible children).

However, it may be necessary to require KidCare plans to offer three benefit packages because aligning the current Florida Healthy Kids and Medicaid benefit packages would have a substantial fiscal effect (estimated at an additional $40 per member per month for each child currently in Florida Healthy Kids). In this modification to the consolidation model, the KidCare plans would offer a Medicaid benefit package, a Florida Healthy Kids benefit package and a Plus package for children with special health care needs. The most significant drawback to having three different benefit packages is that a child's eligibility would be immediately identifiable as either Medicaid or SCHIP, thus losing the transparency afforded by only having two benefit designs.

To administer the program, AHCA would expand its fiscal agent and choice counseling contracts to include a system for helping families choose among plans, a system for collecting premiums, and a system for facilitating interactions with families. DCF would need expanded eligibility determination resources. The Florida Healthy Kids Corporation, CMSN, and the KidCare Coordinating Council would be subsumed under AHCA's administrative structure. AHCA would be required to promulgate rules for the program.

In order to minimize any disruptions to families, the consolidation initiative could be implemented on a staggered basis over several years, maybe partnering with the current Medicaid Reform initiative in its pilot sites (Baker, Broward, Clay, Duval, and Nassau Counties).

The advantages to comprehensive consolidation would be a clear line of accountability, simplified entry into the program and transitioning for families, and reduced administrative costs. Disadvantages would be the loss of brand identification (especially the branding value of Florida Healthy Kids and CMSN), the need for additional public resources to provide a higher level of benefits to Title XXI eligibles if the benefit package was increased to the Medicaid level (this would not be the case if benefit levels were not modified), and additional strain on existing public functions, particularly eligibility determination.

SCHIP Reauthorization

When the SCHIP program was created in the Balanced Budget Act of 1997, the program was authorized for ten years. Congress will consider reauthorization in 2007. Congress has already started preliminary hearings concerning SCHIP.

There are several issues that will be considered during the debate on reauthorization. First, Congress is considering whether to freeze annual appropriations at the 2007 level ($5.04 billion) in perpetuity. Advocates are concerned that this would cause most states to exhaust their federal allotments and create shortfalls. Congress will also consider whether to change the allocation formula to redistribute funds from states that have not used their annual allotments to those that have expanded their programs. Other issues include repealing certain eligibility restrictions, especially the prohibition against dependents of state employees from being eligible for SCHIP.

Because SCHIP has maintained bi-partisan support, the main struggle will likely be over total appropriations and the allocation of these appropriations between states that have expanded their programs over the years versus those states that have operated more limited programs.

RECOMMENDATIONS

The Legislature should consider comprehensive consolidation of the administration of the Florida KidCare Program under AHCA and DCF including: marketing and outreach; eligibility determination;

contracting with managed care plans and fiscal agents; quality assurance; and financing. The consolidation could be piloted in the counties where Medicaid Reform is being implemented. The consolidation should occur after Medicaid Reform has been implemented for at least one year and when existing Florida Healthy Kids and CMSN contracts are up for renewal. Also, AHCA and DCF should provide an assessment of resources needed to incorporate the administrative activities provided by the Florida Healthy Kids Corporation that are not being conducted by either entity at the current time (i.e., premium collection, etc.). AHCA should be directed to conduct a fiscal analysis of consolidating the current benefit packages into a standard package that provides most services for most children and a "KidCare Plus" package for children with special health care needs. AHCA should be directed to identify where waivers of applicable federal law would be necessary to implement this consolidation. State statutes should be conformed to reflect this consolidation.

In lieu of comprehensive administrative consolidation, the entities that operate the Florida KidCare Program should continue their progress on implementing administrative improvements through information technology systems and continuous quality improvement. Under this alternative, the Legislature should:

- continue or expand financing of marketing and outreach activities;
- allow new partners to conduct marketing and outreach;
- require the same eligibility information and documentation to be submitted by all applicants regardless of the KidCare component for which the child may be eligible;
- reduce or eliminate the gap in coverage when children transition between components by allowing Medicaid HMOs and other providers to identifying their members losing eligibility and assist them in completing a KidCare application;
- determine if a waiver is necessary to expand Medicaid eligibility for a limited time to allow families transitioning from Medicaid to Healthy Kids to complete the application process; and
- require the program principals to adopt administrative rules for the entire KidCare program, especially to clarify the policy authority governing the Florida Healthy Kids Corporation and its activities.