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REPORT

FINAL REPORT

Congressionally Mandated Evaluation of the Children's Health Insurance Program: Florida Case Study

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ACRONYMS

AHCA	Agency for Health Care Administration
B-Net	Behavioral Health Network
CARTS	CHIP Annual Report Template
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CKF	Covering Kids and Families
CMS	Children's Medical Services
DCF	Department of Children and Families
DOH	Department of Health
ELE	Express Lane Eligibility
EMR	Electronic medical records
ESI	Employer sponsored insurance
FHKC	Florida *Healthy Kids* Corporation
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HMO	Health Maintenance Organization
IVR	Interactive Voice Response
M-CHIP	Medicaid Expansion CHIP
PCCM	Primary Care Case Management
PCP	Primary Care Provider
S-CHIP	Separate CHIP
SEDS	Statistical Enrollment Data System
SSA	Social Security Administration
TPA	Third Party Administrator
WIC	Women, Infants, and Children

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I. BACKGROUND AND RECENT HISTORY

KidCare—the name given to the set of four children's public health insurance programs in Florida—was created in 1998 in response to the establishment of the Children's Health Insurance Program (CHIP), passed by Congress as Title XXI of the Social Security Act in 1997. The largest component of *KidCare*, *Healthy Kids*, was based on an existing state program that began in 1990 to test school-based alternatives for expanding coverage to uninsured children, and was one of three state programs in the nation given "grandfathered" status under Title XXI (Harrington and Black 2003).

Administered in partnership by four different agencies, *KidCare* encompasses four separate programs for children (see Figure 1):

1. ***Healthy Kids.*** This is the largest of the three Title XXI separate CHIP components in Florida, covering children who are 5 years old with family incomes from 133 to 200 percent of the Federal poverty level (FPL), and children ages 6 through 19 from 100 to 200 percent of the FPL. Administered by the Florida *Healthy Kids* Corporation (FHKC)[1], this program is funded with Title XXI funding and has a full buy-in component. The buy-in covers children ages 5 through 18 with family incomes more than 200 percent of the FPL.[2]

2. ***MediKids.*** This component of Florida's separate CHIP program covers children from ages 1 to 4 whose families have incomes from 133 to 200 percent of the FPL. The state's Agency for Health Care Administration (AHCA) administers this program; eligibility is determined by FHKC; FHKC subcontracts eligibility determination and premium collection to a third-party administrator (TPA). Like *Healthy Kids*, *MediKids* also has a full-pay buy-in component for children ages 1 to 4 with family incomes more than 200 percent of the FPL.

3. ***Medicaid and Medicaid expansion.*** The Medicaid (Title XIX) program covers children ages 0 to 1 whose families have incomes under 185 percent of the FPL, from ages 1 to 5 up to 133 percent of the FPL, and from ages 6 through 18 up to 100 percent of the FPL. A Title XXI Medicaid expansion (M-CHIP) component covers children younger than age 1 with family incomes between 186 and 200 percent of the FPL. AHCA administers Medicaid and the M-CHIP expansion; the Department of Children and Families (DCF) determines eligibility for both programs.

4. ***Children's Medical Services (CMS) Network.*** This health insurance program focuses on children with special health care needs, as determined by clinical eligibility criteria, and is available for children ages 0 to 19 with family incomes less than 200 percent of the FPL. The program is funded by Titles XIX and XXI and is jointly administered by the Department of Health (DOH) (for physical health care needs) and DCF (for specialized

[1] Florida's *Healthy Kids* Corporation is not a state agency. It is governed by a Board of Directors with appointees from the Florida Department of Financial Services, the Department of Children and Families, the Agency for Health Care Administration, the Florida Department of Health, the Florida Department of Education, physicians, a dentist, and other experts on children's health policy and medical care. Board members are appointed by Florida's Chief Financial Officer and the Governor.

[2] The buy-in programs in Florida do not use any Title XXI funds.

behavioral health care, known as the Behavioral Health Network or B-Net). Although DOH nurses determine clinical eligibility, both FHKC and DCF handle the other eligibility aspects (depending on whether the child would be Medicaid- or CHIP-eligible if not for the special health care needs).

KidCare has undergone changes in recent years. For example, after Congress reauthorized CHIP in early 2009, Florida made several simplifications. The one that has had the biggest effect, both from administrative and beneficiary standpoints, was the implementation of electronic verification of financial eligibility for the program. This change means that most families no longer have to provide income documentation to obtain or renew their coverage: the state can use its databases to verify the income of about 80 percent of its applicants. However, other changes have negatively affected program enrollment. For example, in 2008, enrollment in *Healthy Kids*, *MediKids* and *CMS* Title XXI was disrupted for more than a year when a new TPA experienced operational problems when taking over the eligibility, enrollment, renewal and premium collection functions for FHKC. State officials report that *Healthy Kids* operational problems stabilized by November 2009, the same time that the program implemented a citizenship documentation and residency requirement for new enrollees and anyone renewing CHIP coverage as required by CHIPRA. This last change, implemented over the course of a year, again decreased both enrollment and renewals according to key informants.

As of December 2011, monthly enrollment was 251,450 children across the various CHIP programs, and state officials reported a slight uptick in enrollment in the early months of 2012.[3] At the same time, the program struggled with retaining enrolled children*;* on average the CHIP program (all components of CHIP) loses about 17,000 children a month, roughly 7 percent of its average monthly enrollment. *Healthy Kids* reports that it registers about the same number of new enrollees, as disenrollees each month, so monthly enrollment remains essentially flat. Although some children leave CHIP because they are no longer eligible, administrators believe they are losing children who remain eligible, along with not enrolling all the children who are likely eligible for the program but uninsured (the most recently published statistics report that 12.7 percent of all children, and 17.2 percent of low-income children, were uninsured in the state in 2009 [Georgetown Center for Children and Families 2011]). Although many think the Affordable Care Act will help connect the many eligible but unenrolled children (and adults) to coverage in Florida, there is still a great deal of uncertainty in how the various CHIP components might change and fit into new affordable insurance exchanges (a new form of subsidized coverage) in 2014. After the Supreme Court ruling on the Affordable Care Act in June 2012, Governor Rick Scott stated that the state would not implement a Medicaid expansion or state-run exchanges (Scott 2012). However because state legislators determine Florida's Medicaid budget, lawmakers may still have a voice in whether or not the state will offer these optional provisions, making the state's official position "undecided" at the time of this writing (Tampa Bay Times 2012).

This report summarizes findings about Florida's *KidCare* from a case study conducted March 12-16, 2012 by staff from Mathematica Policy Research on behalf of the Assistant Secretary for

[3] This count includes only the subsidized components of CHIP. There were an additional 26,760 full-pay CHIP enrollees (Florida *KidCare* Coordinating Council 2012).

Planning and Evaluation (ASPE), the agency supervising the contract.[4] Florida was selected as one of 10 states being studied in the current congressionally mandated study of CHIP authorized by the CHIP Reauthorization Act (CHIPRA). The case study covers the period from 2006 to the present, with a special focus on changes to the CHIP aspects of *KidCare* and changes the state made in response to CHIPRA legislation. For background information, we drew extensively on findings from the first congressionally mandated study of *KidCare* implementation (Harrington and Black 2003).[5]

In addition to interviewing 31 key informants (listed in Appendix A) in Tallahassee and Tampa, researchers conducted three focus groups for the study: one with parents of children currently enrolled in the CHIP program for children with special health care needs (the CMS Network) in Tallahassee; one with Spanish-speaking parents of children likely eligible for but not enrolled in *KidCare,* in Dover (a rural area east of Tampa); and one with parents of children currently enrolled in *Healthy Kids* in Tampa. In all, 25 parents participated in these focus groups.

The remainder of this case study will describe recent *KidCare* program developments and their perceived effects in the key implementation areas of: eligibility, enrollment, and retention; outreach; benefits; service delivery, quality, and access; cost sharing; crowd out; financing; and preparation for health care reform. The report concludes with cross-cutting lessons learned about the successes and challenges associated with administering Florida's *KidCare* program.

II. ELIGIBILITY, ENROLLMENT, AND RETENTION

Florida's complex structure for its various *KidCare* program components is echoed by an equally complex set of diverse eligibility and enrollment arrangements. This complexity appears to adversely affect children's access to coverage, as will be described later in the report. To help explain *KidCare*, we first review program eligibility rules and processes, enrollment and application processes, enrollment trends, and retention policies and practices.

A. Eligibility

Figure 1 shows the eligibility rules, by age and income, for all *KidCare* programs. Eligibility for children qualifying for subsidized coverage did not expand between 2006 and 2011. Beyond age and income, Florida requires that children in families with incomes less than 200 percent of the FPL (that is, subsidized children) must wait two months before subsidized coverage can begin if coverage was voluntarily canceled or if they do not meet a good-cause exemption (Florida CHIP Annual Report Template [CARTS] 2010).[6] Per Federal rules, children in the Title XXI-funded components must be uninsured, ineligible for Medicaid coverage, U.S. citizens or qualified noncitizens, not residents of a public institution, and reside in Florida. Before 2009, applicants could self-declare

[4] Since this site visit was conducted before the Supreme Court ruling on the constitutionality of the Affordable Care Act, this report largely reflects Florida's CHIP program and policy developments prior to the ruling, although relevant updates have been made to the extent possible.

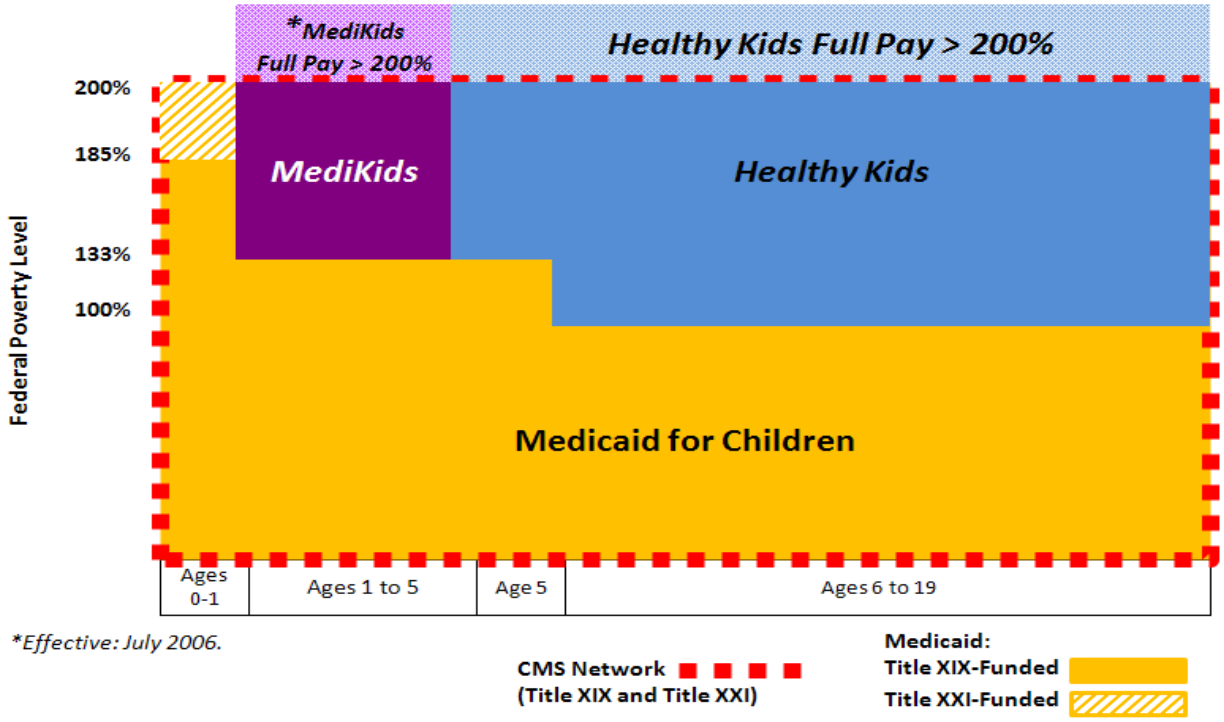
[5] Using other published data and information provided by key informants, we note important policy changes from the three-year period preceding the study (2003 to 2005) when relevant.

[6] The State offers a number of good-cause exemptions, including affordability exceptions.

citizenship; beginning in fall 2009, all applicants and those renewing had to prove both citizenship and identity. This change was instituted to comply with CHIPRA requirements.

Healthy Kids has always had a buy-in component; families with incomes greater than 200 percent of the FPL can pay the full premium amount (currently, this amount is $133 per child for *Healthy Kids* and $196 per child for *MediKids).* No state or Federal funds support the buy-in group. In its 2008 session, the Florida legislature removed the limit on full-pay enrollees (previously, full-pay enrollees could comprise only 10 percent of total enrollment). Informants said that the limit had been instituted because of concerns about adverse selection, but FHKC found that adverse selection was not a problem among the full-pay population. Florida's *KidCare* legislation always permitted a buy-in component in *MediKids,* but this was not implemented until July 2006. There is no buy-in component for the CMS Network; children with special health care needs with family incomes greater than 200 percent of the FPL can enroll in *MediKids* or *Healthy Kids* (depending on their age) paying full premiums, but they cannot access special needs services through the CMS Network. Likewise, there is no buy-in for infants younger than age 1 with family incomes greater than 200 percent of the FPL. Although legally residing immigrant children are not covered by any subsidized *KidCare* programs (although CHIPRA permits this), they can buy in at the full-pay rates.

Figure 1. Eligibility Rules, By Age and Income for all *KidCare* Programs



Source: Florida *KidCare* Coordinating Council 2012

Children enrolled in *KidCare* also could not be dependents of state employees, but this has recently changed: in its 2012 session, the legislature extended CHIP coverage to children of state employees who otherwise meet eligibility rules, an option permitted through provisions of the Affordable Care Act. The expansion was signed into law by the governor on March 29, 2012, and

will go into effect July 1, 2012 (Pillow 2012).[7] FHKC estimates this expansion will enroll about 2,000 new children into either *Healthy Kids* or *MediKids*, and most informants think it will save the state money in the long run (which is why it had support in the legislature). Beyond this planned expansion to children of state employees, there have been no changes to subsidized program eligibility in Florida since 2006, nor have there been threats to existing coverage levels. Key informants feel that the maintenance of effort (MOE) requirements for CHIP stipulated by the Affordable Care Act were inconsequential in Florida for these reasons.[8]

Table 1 summarizes the current eligibility policies for Medicaid and CHIP in Florida. Both CHIP and Medicaid verify income and citizenship, but otherwise, eligibility policies in the two programs differ. For example, Medicaid has both retroactive and presumptive eligibility policies, whereas CHIP does not; CHIP has continuous 12-month eligibility, but Medicaid provides 12 months of coverage only for children younger than 6.

Table 1. CHIP and Medicaid Eligibility Policies

	CHIP	Medicaid	Details
Retroactive Eligibility	No	Yes	Medicaid may be authorized for up to three months before the date of application
Presumptive Eligibility	No	Yes, pregnant women and newborns only	
Continuous Eligibility	Yes, 12 months	No	Families on Medicaid are supposed to report income changes within 10 days so that eligibility can be reassessed
Asset Test	No	In some cases	Families applying for "Family Coverage" under Medicaid are subject to a countable asset test of $2,000; there is no asset test for families applying for child-only *KidCare* Medicaid coverage
Income Test	Gross income	Gross income	
Citizenship Requirement	Yes	Yes	
Identity Verification	Yes	Yes	Since FFY 2008, the *KidCare* application requires a signature to attest to the child's identity
Redetermination Frequency	12 months	6 or 12 months, depending on age	Children younger than 5 receive 12 months of eligibility; those ages 6 to 18 in Medicaid receive 6 months of coverage

Operationally, FHKC determines CHIP eligibility and DCF determines Medicaid eligibility. FHKC selected a new TPA vendor, Affiliated Computer Services, Inc. (ACS, now Xerox); ACS began operations in May 2008. ACS is responsible for application and renewal processing, including CHIP eligibility determination, customer service, and payment processing. At start-up there were significant transitional and operational problems including a lack of communication with families and a backlog of applications, renewals, and other documents (Florida *KidCare* Coordinating Council

[7] The Florida Association of Counties, as well as some individual counties, plan to file suit against the State over other provisions of this bill that require the counties to pick up a significantly increased share of uncompensated hospital care (Wells 2012). It is not known if the lawsuit over this other provision would delay implementation of the State employees' coverage provisions.

[8] The Affordable Care Act stipulated that States must maintain minimum eligibility and enrollment standards (known as MOE requirements) in CHIP (as well as in Medicaid) that are at least as generous as those in place when the legislation was enacted on March 23, 2010 (P.L. 111-148).

2009). Key informants also said that the TPA incorrectly dropped 50,000 children from coverage between May and November 2008, leading policymakers to suspend disenrollment from November 2008 to January 2009, while the TPA improved its processes. To address specific problems it had identified, for the month of November 2008 only, FHKC extended a 30-day grace period for families not in compliance with annual renewal rules, used TPA funds to pay premiums for families, and waived the 60-day lockout period for families who made a payment (Florida *KidCare* Coordinating Council 2009). FHKC believes these emergency procedures prevented 20,000 disenrollments that month; by December 2008, the TPA's processes had improved. In addition to requiring a corrective action plan, FHKC withheld $11 million in liquidated damages from the TPA. Although most key informants believe the program had recovered from these challenges by 2009, at the time of this writing, the current TPA's contract is nearing its end and the state has selected a new TPA for the program; they expect the new contractor to take over operations by August 1, 2013.

Prompted by the passage of CHIPRA, state legislation to administratively simplify several aspects of *KidCare,* including eligibility, passed in 2009. Important changes included mandating electronic verification to determine financial eligibility; codifying for the first time reasons for good-cause cancelation of coverage and removing the 60-day waiting period for families that had canceled other coverage for good cause; reducing the lockout period for nonpayment of premiums from 60 to 30 days; and other minor changes. The passage of CHIPRA engendered support for these changes, which had been historically advocated for by the Florida *KidCare* Coordinating Council (an oversight committee in existence since 1998 composed of various stakeholders).[9]

In January 2010, Florida submitted a state plan amendment to the Centers for Medicare & Medicaid Services for an Express Lane Eligibility (ELE) process, in which it hoped to have an existing data matching process with DCF recognized as ELE, but it was turned down.[10] FHKC has begun discussions with the state's Department of Education about an ELE program with the free and reduced-price lunch program, but at the time of this writing, this appeared unlikely.[11] Advocates believe if they had data to show that ELE would save the state money, it might be feasible to pass something legislatively to support it. Having an ELE program could help qualify the state for Federal bonus money available through CHIPRA, but Florida reports that to revise policies to qualify for bonuses would require both legislative changes and additional state funding.[12] The state

[9] The Florida *KidCare* Coordinating Council was created in Section 409.818(2)(b), Florida Statutes, and is responsible for making recommendations concerning the implementation and operation of *KidCare* (Florida *KidCare* Coordinating Council 2012).

[10]Beginning in 2009, FHKC started receiving a file each night from DCF of children denied Medicaid for income reasons, or who had been enrolled in Medicaid but were now ineligible. FHKC processes the cases and sends the families a letter telling them they are CHIP-eligible if they pay the premiums. It was this process that the State wanted to recognize as ELE.

[11] Currently, the free and reduced-price lunch program is administered separately by each of the State's 67 counties; each county uses its own form, requiring different information and maintained in different ways (sometimes in a computer, other times in handwritten forms). For this to be feasible, FHKC would like the counties to move to a single, Statewide form for free and reduced-price lunch that could be sent to the Department of Education and then shared with FHKC. Given that there is no funding to support such an effort, it is not likely to occur. Effective January 1, 2013 the Department of Agriculture will become responsible for the School Lunch Program; it is not clear whether this will impact FHKC's efforts to implement ELE in partnership with the school lunch program.

[12] CHIPRA instituted a reward system whereby States that implemented at least five of eight program simplifications and increased Medicaid enrollment could qualify for Federal bonus money.

projects that the cost to implement the needed changes far exceeds the potential bonus payments (Florida CARTS 2010).

B. Enrollment and Application Processes

Florida offers a joint, online application for CHIP and Medicaid, but if a family is applying for Medicaid for adults and children (as opposed to children only), it uses a separate application available from DCF.[13] Table 2 summarizes current application requirements and procedures in Florida CHIP.

Table 2. Current CHIP Application Requirements and Procedures

Form	
Joint Application with Medicaid	Yes
Length of Joint Application	4 pages; 2 pages of instructions, 2 pages of application
Languages	English, Spanish, Haitian Creole
Application Requirements	
Age	Yes – self-declared
Income	Yes – income is electronically verified; if the state cannot verify it against other databases, documentation must be submitted
Deductions	Yes – day care and after-school child care costs
Social Security Number	Yes – self declared; CHIP does not data match with the Social Security Administration
Citizenship	Yes – real-time look up in Florida Vital Statistics registry to try to verify citizenship; if it cannot be determined through this match, family must provide documentation of citizenship
Enrollment Procedures	
Express Lane Eligibility	No
Mail-In Application	Yes
Telephone Application	No
Online Application	Yes
Hotline	Hotline available, but cannot apply by telephone
Outstationed Application Assistors	In some places in the state, yes, but not statewide
Community-Based Enrollment	No, centralized enrollment

The typical enrollment route for a family seeking child coverage through CHIP is to complete the joint application online (89 percent of applications are submitted online). It can be completed and signed online, or a family can print a portable document format (PDF) version of the application, which can be faxed or mailed. The family must report its demographic information, for whom it is

Focus Group Findings: Applying for Coverage

Several parents concurred that the application process had improved over time, but still takes longer than expected to enroll.

Now the application process was better – it felt like forever, but it was much easier than when I first applied years ago.

It's a long process, like 6 to 8 weeks to wait to see if you are eligible.

[13] Called the DCF Access application, families can separately or jointly apply for Medicaid, food assistance, and cash assistance either online through DCF or using a paper copy.

applying for insurance, whether the child currently has insurance coverage, and whether the parent has canceled insurance coverage for this child in the past two months (a copy of the application is in Appendix B). There also are three questions about the child's health, which constitute the initial screening for the CMS Network; answering yes to any of these three questions launches the clinical screening process for CMS (with nurses from CMS following up with the family and providers for more information). Finally, the family reports its monthly earned and unearned income, child support received, and any amounts the family pays for after-school child care or day care.

Whether applying online, by mail, or by fax, all joint applications go to the state's TPA.[14] The TPA uses a logic program to screen all applicants for Medicaid eligibility. The TPA sends all applications to AHCA nightly in an electronic file through a batch process to first determine if the child is already enrolled in Medicaid. If the child is not already enrolled in Medicaid, the application is then sent electronically to DCF (also in an overnight file), which formally determines Medicaid eligibility. DCF has 45 days to determine whether a child qualifies for Medicaid. When the DCF eligibility screening begins, DCF sends a letter notifying the family that its child is being considered for Medicaid coverage.

For all of the children who appear eligible for any Title XXI-funded programs or for full-pay programs, the TPA performs a data match with both Department of Revenue and the Department of Economic Opportunity for Unemployment Compensation (to verify income) and a real-time data look up with Vital Statistics (which can verify citizenship). If income and citizenship can be verified through these systems, the family does not have to provide any additional documentation. For families whose information can be validated through the data matching processes, it takes about 7 to 10 days to process the application. The processing time for families needing to submit additional documentation varies, depending on how quickly the family sends the required documentation; an application can remain in the TPA's system for 120 days, at which point state rules require a denial letter to be issued. Successful applicants are mailed a letter of approval with both premium information (a 12-month coupon book, as well as the premium amount) and health plan information. (As will be discussed further [see Section V.A., Service Delivery], *Healthy Kids* auto assigns children into managed care plans, whereas Medicaid and *MediKids* send health plan information by mail and allow families to select a plan.) Technically, the family is supposed to submit the first premium payment by the 21st day of the current month for CHIP coverage to begin on the first day of the following month, although the state will accept payment up to midnight on the day before the coverage month begins.

Focus Group Findings: Medically Needy Program

"Share of costs" coverage, the State's Medically Needy Medicaid program, is poorly understood and confusing to parents who receive notification that they are eligible. Parents of *KidCare* enrolled children at two different focus groups described difficult experiences with this program.

They said the share of cost would be $2,000, which is more than we were bringing in. I don't understand exactly how it works to access care.

Share of cost was a nightmare and KidCare was a good change from that.

$15 a month is better than having the shared cost.

If a family is determined ineligible for Medicaid (at application or renewal), DCF is supposed to refer the file back to FHKC's TPA for assessment for *MediKids*, *Healthy Kids*

[14] Mailed or faxed forms are scanned into the TPA's computer system so there is an electronic version.

or Title XXI CMS. To smooth this process, in 2009 *Healthy Kids* implemented a modified administrative process with DCF in which the TPA can accept the income information from DCF to determine eligibility for Title XXI without requiring the family to submit the information again (Florida *KidCare* Coordinating Council 2012). However, several informants indicated that this process does not always work as designed and that the correspondence from DCF to the family confuses the issue: DCF issues a letter saying that the child was found ineligible (or no longer eligible) for Medicaid, but that the case is being referred to FHKC to see if the child qualifies for other *KidCare* coverage. Many informants report that when parents receive this letter, they understand only that their child has been dropped, not that they might qualify for other insurance, and that sometimes they disregard or do not receive other paperwork from FHKC. Moreover, a number of respondents indicated that, more often than the referral that is supposed to happen, these families are issued a letter from DCF saying they are eligible for "share of costs," the state's Medically Needy Medicaid program, which requires families to incur a certain amount of expenses (from several hundred to several thousand dollars, depending on the family's income) to trigger coverage.[15] Some informants said that the process is not automated: DCF workers have to enter a specific code for the electronic referral back to FHKC, and this code is often entered incorrectly.

If families need help with their applications, renewals, or have any questions, the *KidCare* hotline is available to help answer general customer service questions for all of the Florida *KidCare* programs. Operated by the TPA, it also has an interactive voice response (IVR) system for automated assistance. The hotline takes between 4,500 and 5,000 calls per day and has staff available to respond in English, Spanish, and Creole between 7:30 a.m. and 7:30 p.m., Monday through Friday. Consumers can access the IVR 24 hours a day, which enables callers to perform a number of automated functions including requesting an application, checking their application status, or paying by telephone. Key informants reported the current average response time by a live operator to be 15 seconds.

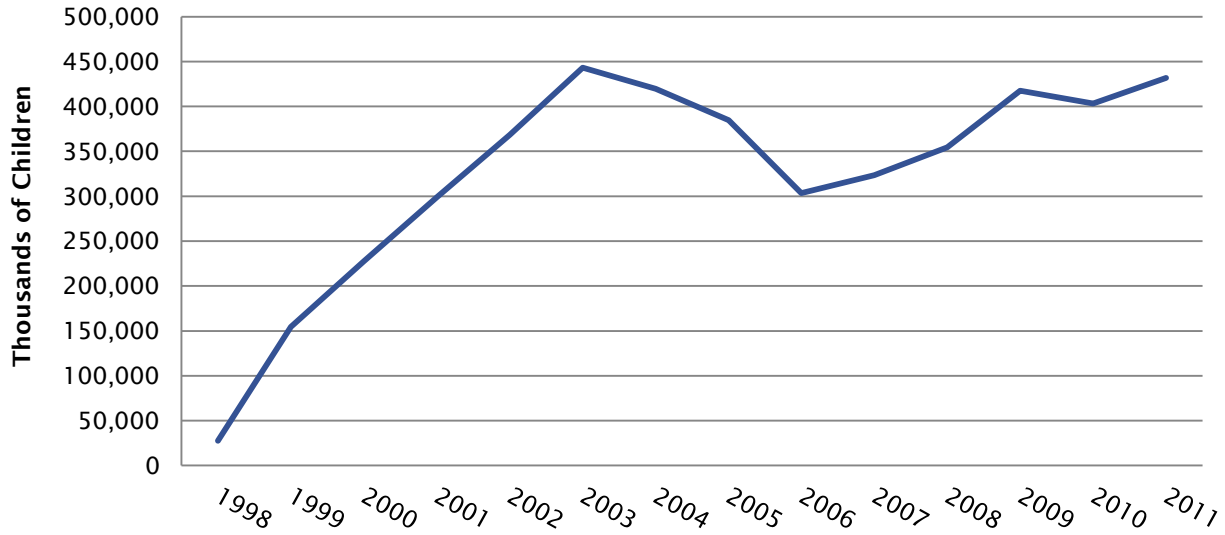
C. Enrollment Trends

Figure 2 shows the number ever enrolled each year in the Title XXI components of *KidCare* from Federal FY 1998 through 2011. The number ever enrolled in CHIP grew through Federal FY 2003, then declined through Federal FY 2006.[16] Enrollment climbed again from Federal FY 2006 to Federal FY 2009. The number ever enrolled dropped from Federal FY 2009 to 2010, but picked up again in 2011 (and although 2012 numbers are not yet available, administrators reported an uptick in enrollment in the first two months of 2012).

[15] The medically needy program is a Medicaid program for people who have too much income (or assets) to qualify for Medicaid. According to the State, the program establishes a "share of cost" based on the individual's family monthly income. Each month, certain medical expenses incurred or paid can be counted toward the share-of-cost amount. When the allowable expenses equal the share of cost, the person is eligible for Medicaid for the rest of the month (Florida Department of Children and Families 2012).

[16] Although the period 2003-2005 precedes the period of interest for this case study, beginning in 2003 several policy changes were implemented that drove enrollment down, including instituting a 6-month cancellation of coverage policy for premium non-payment, as well as halting new enrollment and establishing a waitlist in July 2003 (later rescinded, although year round open enrollment was not reinstated until July 2005), among others (see Florida *KidCare* Coordinating Council [2012] for more detail).

Figure 2. Enrollment, All Florida CHIP Programs, Federal FYs 1998 to 2011

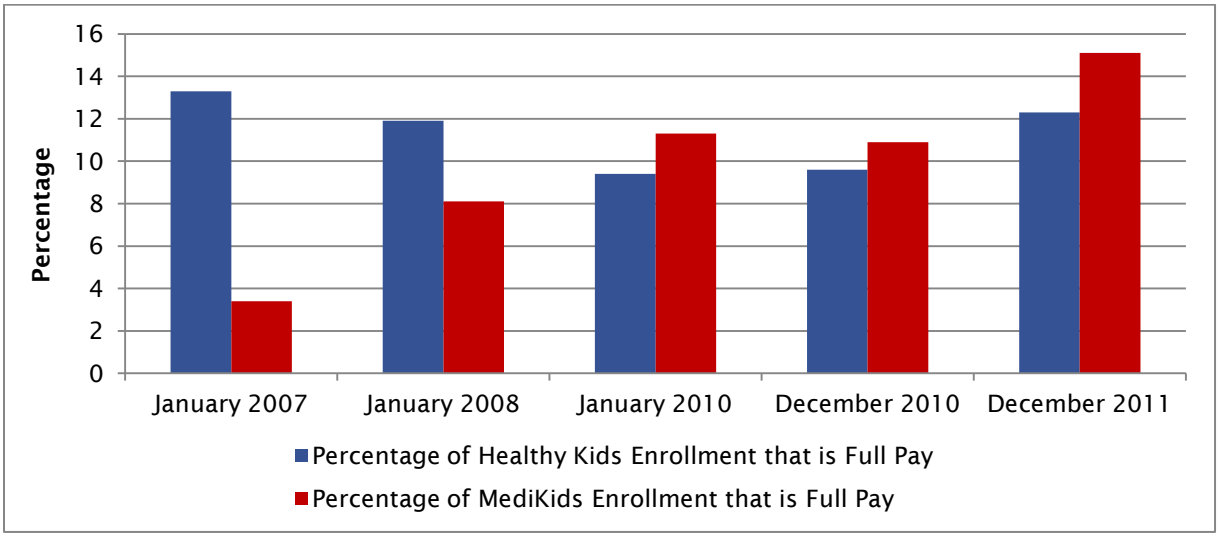


Source: Statistical Enrollment Data System (SEDS) Centers for Medicare & Medicaid Services, CHIP SEDS as of February 18, 2011, verified and provided by Centers for Medicare & Medicaid Services. 2011 data accessed on May 14, 2012.

Note: The data presented above includes All of Florida's CHIP Programs: *Healthy Kids, MediKids,* and Title XXI CMS

As a percentage of the total, enrollment in the full-pay component of *Healthy Kids* fell from 2007 to 2010 but increased in 2011 (Figure 3). In *MediKids*, enrollment in the full-pay component has steadily increased since it was implemented in 2006; it now represents about 15 percent of all *MediKids* enrollment.

Figure 3. Percentage of *Healthy Kids* and *MediKids* Enrollment that Is Full Pay, 2007 to 2011



Source: Florida *KidCare* Coordinating Council 2012.

D. Renewal

Florida's *Healthy Kids, MediKids,* and *CMS Network* garnered national attention in their early history by operating a completely passive renewal system, which automatically renewed children's coverage as long as their premium payments were up to date and essentially eliminated disenrollment of children for paperwork reasons (Harrington and Black 2003).[17] Because of concerns about fraud in the program and budget pressures, Florida's legislature required CHIP to switch to an active renewal process in 2004.

Currently, enrollees in Florida's CHIP programs receive 12 months of continuous eligibility (Table 3). Sixty days before the 12-month enrollment period ends, the state's TPA mails the renewal form, which is pre-populated. If nothing has changed, families must sign and return the form; if income has changed, families must submit new income information.[18] The renewal form can be submitted online (with e-signature, although if income documentation is required, it must be sent separately or emailed), by fax, by email (scanning the signed form and attaching it), and by mail. If families send back at least one piece of information—for example, the renewal form, but not new income information—they are given an additional 30-day grace period to renew, because they have demonstrated intent to renew.[19]

Table 3. Renewal Procedures in Florida CHIP and Medicaid as of January 2012

	Renewal Requirements	
	CHIP	Medicaid
Passive/Active	Active	Active
Ex-Parte	No	No
Rolling Renewal	No	No
Same Form as Application	No	No
Preprinted/Pre-populated Form	Yes	Yes unless income has changed
Mail-In or Online Redetermination	Form is mailed by the state but can be returned by mail or submitted online	Form is mailed by the state but can be returned by mail or submitted online
Income Documentation Required at Renewal	Family notified by mail if state cannot administratively verify the family income (reportedly most families do not have to submit documentation)[a]	Yes[b]
State Administratively Verifies Income	For most enrollees, yes[a]	No
Other Verification Required	No	No

[a] Administrative verification is done for about 80 percent of enrollees; those with income from the Social Security Administration (SSA) or self-employed cannot be administratively verified, and they must submit income verification.

[b] Families are required to provide eight consecutive paystubs if their income has changed for each renewal.

[17] According to Herndon and Shenkman (2005), under passive renewal, families in Title XXI components of *KidCare* coverage received a letter notifying them their children's coverage reached the renewal stage. Families were asked to contact the program if there were any changes to the family's income or insurance status, but if there were no changes, families did not have to respond. Nonrespondent families maintained coverage for their children if they continued to pay premiums. Under active renewal, all families had to provide documentation to verify program eligibility at redetermination.

[18] If demographic information has changed, families can just write in the new information.

[19] Initially, when the State switched to active renewal, the grace period was 120 days, but an audit revealed that the State typically received the renewal within the first 30 days or not at all; it therefore switched to a 30-day grace period.

After all renewal documentation is returned, CHIP renewals are processed quickly; FHKC estimates it takes fewer than 20 minutes to process a renewal. The state then mails a completion letter to every successfully renewed beneficiary, with a new coupon book for the family to pay its premiums for the next year of coverage. Since 2004, FHKC has made outbound calls to renewing families, and beginning in 2009, initiated an email campaign (for families with an email address on file) to remind families to renew, in addition to the regular mailing for renewal.

Administrative renewal (using pre-populated forms) is a recent change implemented in 2011 (permitted by 2009 legislation). FHKC estimates that it has access to data to complete administrative renewals for 80 percent of all CHIP enrollees (*Healthy Kids, MediKids,* and Title XXI CMS). The remaining 20 percent of enrollees—mostly those with Social Security income and those self-employed—are primarily the beneficiaries who still have to document their income.[20] In either case, the family must submit the signed form to the state.

The *Healthy Kids* health plans know members' renewal dates and although the TPA handles the renewal process, health plans can (and all do, although it is not required) reach out to members at renewal, typically mailing reminder postcards, making telephone calls, or emailing a renewal reminder (sometimes all three methods are used). Given that enrollment drives their funding, plans recognize it is in their best interest to maintain enrollment and are actively involved in reaching out to families to remind them to renew.

The renewal processes for Medicaid and CHIP are different in Florida, as are the renewal periods for most children (children younger than 5 also receive 12 months of eligibility in Medicaid, but the eligibility period is only 6 months for children ages 6 to 19). Medicaid uses a different form, which is mailed to the beneficiary. This form can be completed online, mailed back to DCF, or a beneficiary can return it in person to a local DCF office. If more information is needed, a caseworker contacts the family. [21]

Focus Group Findings: Renewal

In focus groups, parents reported mixed experiences with *KidCare* renewal, with more families reporting good experiences than bad, especially compared to the past.

Renewal was very easy. I actually do it online and since my information is the same, there is only some information that I have to fill in and I send the check in. They actually send (the reminder) to me in email or in the mail."

The renewal has gotten a lot easier.

You can renew online, too. They send an email reminder.

The time of the renewal is difficult. Because we are self-employed, we have to provide a lot of documentation. It would be easier to renew right after tax time when we have all the documents at hand.

[20] Because FHKC is a not a public agency, it cannot data match with SSA, requiring those with SSA income to document it separately.

[21] At any point during coverage (not only at renewal), Medicaid families are supposed to report income changes within 10 days so that DCF can review the case to determine ongoing eligibility. Children younger than 5 who become ineligible for Medicaid for any reason may remain on Medicaid for up to 12 months from the date of most recent application. Children ages 1 through 19 whose families' income has increased to CHIP eligibility levels are supposed to be electronically referred to FHKC for *MediKids* or *Healthy Kids,* depending on the child's age (but as noted earlier, some informants reported that this referral process does not always work smoothly).

Although state officials believe that implementation of administrative renewal in CHIP has improved the process for families (because most families only have to submit the renewal form and do not have to document their income), they know that passive renewal was easier for families: under passive renewal, as long as families continued to pay premiums, their children remained enrolled without them having to do anything. The disenrollment changes shown in Figure 2 support this: the number of children ever enrolled in CHIP dropped by roughly 150,000 from 2003 to 2006 (active renewal was implemented in 2004). Passive renewal was not the only factor that affected enrollment; the legislature implemented a number of other policies that restricted enrollment during this period, including closed enrollment and a waiting list for a period, as well as changing the lockout period for nonpayment of premiums from two to six months. Another more recent barrier to renewal was the proof of citizenship and identity requirements. Beginning in late fall 2009, to comply with CHIPRA rules, all new enrollees had to provide this documentation, as did everyone renewing coverage (once it has been verified, it does not have to be reassessed annually). The state implemented the policy on a rolling basis, timed with enrollees' renewal dates, so it took a year to implement the policy fully. This is no longer a renewal barrier (although still an enrollment barrier), but state administrators acknowledge a drop in renewals when this documentation requirement was implemented (which corresponds to the increase in disenrollments from 2009 through 2010, as Figure 2 shows).

Focus Group Findings: Confusion About *KidCare* Eligibility Rules and Medicaid/CHIP Coordination

In a focus group with parents of children with special health care needs, one parent was convinced her child was assigned to the wrong program (in fact, the child, was correctly assigned to Medicaid). As a result, she did not take the child for services:

My older child is in Healthy Kids, so I knew we were eligible for that. But when my new baby was born, I got a letter saying he was in Medicaid. I knew this was wrong, but I couldn't figure out how to get it corrected. I just didn't use the coverage because I didn't want to take something we didn't deserve.

Some parents mentioned the feeling of being "caught" in a gap between Medicaid and CHIP agencies when their income changed and their child had to transition from one program to the other:

We had an income change and we were just dropped. We were kicked off [of Medicaid] but they said they couldn't sign us up for KidCare until Medicaid puts the letter online that says you are off. Then I'd stay on the [phone] line forever with Medicaid only to find out, "everything is in there that needs to be in there." Then you go back to KidCare, and they say, "no, you need to call so and so and ask for so and so." It was a back and forth and back and forth.

There was a gap in coverage of maybe two months between Medicaid and Healthy Kids. The agencies didn't communicate; they didn't offer to switch to Healthy Kids from Medicaid.

One parent noted a problem as her child aged through the *KidCare* eligibility levels:

After she is a year old, she goes off Medicaid and she gets on KidCare [actually MediKids], but there has to be a letter from Medicaid and you go through all that. They say their systems are connected, but it doesn't seem that way.

FHKC reports that the CHIP program loses about 17,000 children each month, or about 7 percent of average monthly CHIP enrollment. Some amount of disenrollment is expected, as children age out or become income-ineligible, but the state believes that at least a portion of those who disenroll remain eligible. Based on data from the past 12 months, administrators estimate that on average about 6,500 (about 38 percent) are lost due to nonpayment of premiums; 5,700 (or about 34 percent) become Medicaid-eligible; 2,900 (17 percent) fail to renew coverage that month; and the remaining 1,900 are lost for other reasons (including being no longer eligible). However, aside from knowing those who move to Medicaid, the state does not conduct any assessments of disenrollees, so it does not know if families are not paying because they now have private insurance coverage or if the family has failed to pay for another reason.

E. Discussion

The use of four different programs for child health coverage is confusing to families, and it appears that the *KidCare* branding of all children's public insurance programs is not well understood either. The program also is administratively disjointed, with two separate entities responsible for eligibility determinations for Medicaid and CHIP; in total, four agencies are involved in program administration. All four agencies use separate information systems. Several parents expressed confusion that when they had applied for *Healthy Kids,* they received a letter from Medicaid saying their child's eligibility for Medicaid was being assessed—but they had not applied for Medicaid coverage so they did not understand those letters. It seems that although the joint application might administratively simplify the application process for families, the processes for determining application outcomes and the correspondence reporting them to families can be lengthy and are not well coordinated between Medicaid and CHIP. Other families noted their confusion of paying for *Healthy Kids* but getting an insurance card that says *United* or *Wellcare.*

The recently implemented administrative determination of income—in which most families do not have to submit income documentation at application or renewal—should be an improvement at both enrollment and renewal for families, because it reduces their paperwork burden. However, many focus group participants were self-employed and thus still had to document their income. Some parents noted the challenge of providing the right documentation to satisfy the income documentation requirements. One parent who participated in one of the focus groups said it took six to eight weeks to find out if her child was eligible, which felt like a long time to wait for coverage. Application assistors reported the need to do a lot of telephone follow-up about applications and renewals, because information did not come from the state in a timely way.

III. OUTREACH

Funding for *KidCare* outreach has been variable. In its early years, the legislature allocated nearly $7 million annually to support outreach activities (Harrington and Black 2003; OPPAGA 2009).[22] Concerns about funding and program integrity cut this back; beginning in 2005, the legislature allocated $1 million annually to FHKC for outreach activities, but the legislature cut outreach funding entirely in 2008 due to state budget pressures. The FHKC board has increased its own investment in outreach as the legislature began cutting outreach funds, with $1.7 million allocated for 2012, including grants to community organizations and a contract with the University of South Florida. Other agencies involved in *KidCare* also invest in outreach; for example, AHCA has funded a $200,000 outreach contract since 2007.[23] Private and other Federal funding for outreach has also supported the program. In the early years, the Robert Wood Johnson Foundation's Covering Kids and Families (CKF) program supported a grantee at the University of South Florida.[24] More

[22] Most of this funding came from Federal sources, including Medicaid, CHIP, and tobacco settlement funds; some came from general revenue (OPPAGA 2009).

[23] The health plans under contract to *Healthy Kids* are not required to conduct outreach, but many plans in the State do so, focusing on *KidCare* coverage availability. Similarly, the TPA is not required to conduct outreach, but at the time of our visit was in discussions with FHKC about sponsoring some billboards to advertise *KidCare.*

[24] The Robert Wood Johnson Foundation sponsored a nationwide grant program, *Covering Kids and Families*, to sponsor and promote State and local outreach initiatives for CHIP from 2000 to 2007.

recently, the same CKF grantee has qualified for CHIPRA outreach grants of almost $2 million.[25, 26] The CHIPRA outreach grants have permitted CKF to conduct new activities, such as funding three hospitals with the highest number of uninsured pediatric cases to do application assistance on site, and targeting schools in districts with large proportions of uninsured teenagers to provide outreach and enrollment assistance, among others.

Most of the FHKC money (and all of the AHCA money) goes into grants to CKF and other community groups in the state to provide outreach and application assistance.[27] For example, FHKC supports "Boots on the Ground," providing small grants to community partners to do tailored marketing and outreach to families likely to be eligible for *KidCare*. In early 2012, FHKC awarded local organizations with small grants as part of the Regional Navigator Project, a project to recruit and train local organizations to act as certified application assistors, who can then provide direct assistance to hard-to-reach populations.[28, 29]

With outside consultants, FHKC has developed program messages that are available on its website for community partners (or others) to download, should they want outreach materials. Informants told us there are multiple messages, based on the age they target or the event/time of year. For example, at back-to-school time, the message is "This school year, help your child get off on the right foot. Make sure health insurance is on your back-to-school checklist." Other messages include "Affordable health insurance;" "One less

Focus Group Findings: Outreach

Families who participated in focus groups had heard about *KidCare* in a variety of ways, with no one way seeming predominant. Only one parent, of a child likely eligible for *KidCare* but not enrolled, reported they had never heard of *KidCare* or *Healthy Kids*.

I heard through school.

My pediatrician told me.

I saw lots of commercials about it. My children were on Medicaid, but when my Social Security disability came through, we were kicked off Medicaid. They needed constant medical attention. It wasn't a very long wait. I saw a commercial and tried again to sign up.

[25] CHIPRA, together with the Affordable Care Act, allocates a total of $140 million for enrollment and renewal outreach, including $112 million in grants to States, community groups, and health care providers; $14 million specifically for organizations serving American Indians and Alaska Natives; and $14 million reserved for national enrollment campaign activities. Collectively, these are called CHIPRA outreach grants.

[26] In addition to the CKF grantee, two other CHIPRA outreach grants were awarded in Florida: grantees include Fanm Ayisyen Nam Miami (FANM), which received a $69,000 grant in 2009 to provide culturally and linguistically appropriate outreach to the Haitian community in the Miami-Dade county area; and Sacred Heart Health Systems, which received $745,000 in 2011 to promote awareness, enrollment, and retention in six northwest Florida counties.

[27] CKF maintains the AHCA grant to support focused outreach activities for *KidCare;* FHKC's current grant with CKF provides money for CKF to oversee the "Boots on the Ground" grantees and to conduct other outreach activities (such as providing technical assistance and training to community groups.

[28] Navigators receive funding based on the number of applications approved or renewed, and can earn incentives for exceeding enrollment goals. Initial reports indicate that some grantees have had problems producing applications under the per-application-payment mechanism.

[29] There are some other FHKC-sponsored outreach efforts. *Healthy Kids* annually holds an "Act Out for Health" contest, soliciting outreach materials designed by students in grades 4 through 12. Students create a 30-second public service announcement, billboard, or essay. Winners receive scholarships and have their announcements aired and billboards posted, or their essays are read at a Statewide press conference. FHKC also purchases promotional items (hand sanitizers, water bottles, and so on) for distribution at public events (such as school fairs or parades) as well as provides applications and information brochures at routine distribution spots (clinics, libraries, schools, and so on).

worry for parents. A brighter future for kids. Apply now, it's easier!" "Is your child covered?" and "For every stage of your child's life … Florida *KidCare*."

IV. BENEFITS

Except for the expansion of dental benefits and behavioral health parity introduced by CHIPRA, Florida's separate CHIP program benefit package has remained the same since program inception. Florida has a grandfathered benefit package for *Healthy Kids*, with benefits based on the predecessor program. Benefits in the Medicaid-expansion component of the program and in *MediKids* are identical to the Medicaid benefits package. Table 4 summarizes medical, behavioral, and dental health benefits provided through the various CHIP components.

Table 4. Benefits: Florida *KidCare*

	Medical	Behavioral Health	Dental
Healthy Kids state S-CHIP component for children 5 to 18	Comprehensive benefits package; grandfathered package approved by the secretary of the U.S. Department of Health and Human Services; notable limits: 24 treatment sessions per 60-day period for physical, occupational, respiratory, and speech therapies; 100-day per contract year limit on skilled nursing facility services; one pair of glasses every two years; $1 million lifetime limit	Comprehensive package covering mental health and substance abuse outpatient and inpatient services. All limits on mental health and substance abuse services were removed on October 1, 2009, to comply with CHIPRA	Identical to Florida's Medicaid dental benefits package. Effective July 1, 2010, the *Healthy Kids* program eliminated the annual dental limit (previously, had been a $1,000 annual limit)[a]
MediKids state S-CHIP component for children 1 to 4	Comprehensive Medicaid benefits package required by Federal law	Medicaid package required by Federal law	Medicaid dental benefits package
Medicaid and M-CHIP expansion Covers children from birth through age 18	Comprehensive Medicaid benefits package required by Federal law	Medicaid package required by Federal law	Medicaid dental benefits package
CMS Network state S-CHIP component program for children with special health care needs	Comprehensive Medicaid benefits package required by Federal law	Medicaid package required by Federal law plus additional services such as care coordination, home health care, social services, and therapies; school-aged children enrolled in CMS Network with serious emotional disturbances or substance abuse problems can enroll in the *B-Net* program, which offers behavioral health services only; children enrolled receive their physical and dental health through the traditional programs[b]	Medicaid dental benefits package

[a] Florida CARTS 2010.

[b] B-Net participants receive wrap-around services (treatment planning and review; evaluation services; case management; family support; respite; transportation; and residential, rehabilitative, and day treatment services).

Key informants agreed that the *Healthy Kids* benefit package is comprehensive and, in their views, comparable to private insurance coverage. Benefits in *Healthy Kids* are similar but not identical to the Medicaid package; Medicaid offers additional services, such as a transportation benefit and different prescription medical coverage. Some key informants said that they hear complaints about dental (both benefits and access) in *Healthy Kids*. Although administrators view dental benefits as comparable to private dental coverage (particularly since the benefit was expanded through CHIPRA), some key informants think that dental benefits are not well understood by consumers and that enrollees have difficulty navigating the dental side of the system (the state carves out dental services to separate dental insurers). Administrators note that dental care also is even more problematic in Medicaid, which has a smaller, mostly fee-for-service provider network and reportedly lower utilization rates for dental services[30]. Other benefits shortcomings that some informants identified are the limits on certain therapies, particularly speech and physical therapy needed for children with developmental delays and autism. The benefit in *Healthy Kids* is a rehabilitative benefit, meaning the child has to be recovering from something; developmental delays do not qualify according to this definition, and this difference is sometimes hard to clarify to parents.

Focus Group Findings: Benefits

Parents of *Healthy Kids* enrollees who participated in focus groups indicated that they are generally satisfied with benefits.
Benefits are great.
I think what is covered is good.

Some parents did identify problems. For example, one parent said the health plan forced her son to first try other less expensive drugs that did not work:

I try to find out what is covered by going on the web site, but it doesn't give details about what kinds of things are covered.… In the doctor's office, we find out if things are authorized.

Another parent noted that benefits differ between Medicaid and CHIP, which can be problematic for families who transition between the two programs:

It was a back and forth and back and forth, and it is scary if you have a child that is on an antipsychotic medication that does not need to miss a dose. And then of course Medicaid covers medication that KidCare doesn't and vice-versa, so you go through that transition of getting them on a different medication. It's kind of a nightmare.

V. SERVICE DELIVERY, QUALITY, AND ACCESS TO CARE

The intention of all coverage programs is to not only get and keep children enrolled, but to ensure they can and do access services they need, and that care is of high quality. In this section, we review three related topics: service delivery, quality, and access.

[30] Medicaid and *MediKids* are planning to enroll all children in a dental managed care plan in fall 2012.

A. Service Delivery

The delivery systems for the various *KidCare* components vary in their use of managed care and the types of managed care arrangements employed. The Title XXI *KidCare* components make more extensive use of managed care, including capitation-based payment arrangements, than Medicaid. Table 5 provides an overview of service delivery arrangements in the various *KidCare* components.

Table 5. Service Delivery Arrangements in *KidCare*

	Healthy Kids	*MediKids, Medicaid, M-CHIP*	*CMS Network*
Managed Care Contracting	Yes	Some managed care, some primary care case management (where only one health plan serves a county, a child can enroll in primary care case management)	No; DOH staff provide care coordination, and contract directly with local providers for services
Number of Plans Serving Program	7 All but 2 also participate in *MediKids* and *Medicaid*	18 health maintenance organizations 7 provider service networks Primary care case management program	NA
Services Plans Are Responsible for	Physical, behavioral, pharmacy	Physical, behavioral, pharmacy	NA
How Are Mental Health and Substance Abuse Services Provided?	Through the same health plans	Through the same health plans or the primary care case management model selected	Through DOH direct contracts or, for children with a clinical diagnosis of serious emotional disturbance, through a separate network managed by DCF
How Are Dental Services provided?	State carves out dental to two separate managed dental plans	Medicaid and MediKids provide dental services primarily through fee for service arrangements, although the state is beginning to implement managed care for dental; some health plans provide dental through managed dental care plans, depending on where the child lives and which health plan they are enrolled in	Separate network of dental providers paid on a fee for service basis

NA = not applicable.

Florida *Healthy Kids* provides physical, behavioral, and pharmacy services through managed care organizations. Currently, there are seven health plans serving *Healthy Kids*, representing a mix of commercial, profit, and nonprofit plans.[31] Key informants said plan participation has been relatively stable over time. Although a few plans had been added or dropped since 1998, usually plans have remained the same, just changing the counties they cover. FHKC uses a single contract for all

[31] Two of the seven plans operate two separate plans in different parts of the State: Blue Cross has a health maintenance organization and exclusive provider organization, and Wellcare operates both Healthease and Stay Well.

Healthy Kids plans, but negotiates rates separately with each plan. In the current contract, rates are not age-adjusted, but are geographically adjusted by county. The average statewide per member, per month rate in *Healthy Kids* is $110. Rates are required to be actuarially justified and meet an 85 percent medical loss ratio standard. FHKC is currently going through a re-procurement process, which will slightly tweak the geographic rate adjustment options (plans can bid a single county rate for as many counties as they are licensed for, submit a group rate covering specified county groups, or bid a single statewide rate, among other options).

Before CHIPRA passed, Florida did not require *Healthy Kids* enrollees to have plan choice, and counties with fewer than 10,000 enrollees had only one plan available to enrollees. With the passage of CHIPRA, the state was required to have at least two plans in every county. This was a challenge because there are 67 counties in Florida, a number of them rural with small populations. Every county had a choice of plans as of June 1, 2011 (although just one plan (United Healthcare) operates statewide).

AHCA also contracts with managed care plans for the *MediKids,* Medicaid, and M-CHIP programs (all but two of the managed care plans serving these *KidCare* components are the same as the *Healthy Kids* plans), but far more plans participate in *MediKids,* Medicaid, and M-CHIP—in total, 18 health plans and seven provider service networks. On average, the per member, per month rate for *MediKids* is $122 for physical health, behavioral health, and pharmacy services. Because health plans are not available in every county, AHCA also administers a primary care case management (PCCM) program. Children enrolled in Medicaid can choose the PCCM program (called *MediPass*) or managed care, regardless of which county they live in. If children are enrolled in *MediKids*, and reside in a county with a choice of at least two health plans, they must enroll in a plan. But *MediKids* children who reside in counties with only a single health plan can enroll in either the plan or *MediPass*. For children, AHCA uses the same service delivery approaches in Medicaid and M-CHIP as in *MediKids:* some children are enrolled in managed care for physical, behavioral, and pharmacy benefits, whereas many are in the state's PCCM program.

The CMS Network (for children with special health care needs) employs a variety of service delivery arrangements. All enrollees receive care coordination, provided by DOH staff. In some areas of the state, DOH contracts directly with providers to provide integrated care for enrollees in those areas. In regions in which integrated care systems are not available, DOH area offices manage the services, contracting directly with individual providers and helping to arrange for services. For certain specialties, private providers come to local CMS offices to serve the clients. Children in the CMS Network with a serious emotional disturbance diagnosis receive behavioral health services through a separate Behavioral Health Network (B-Net). On average, the per member, per month cost for children in the CMS network is $473 and the state spends an additional $1,000 per member, per month for children enrolled in B-Net (Florida *KidCare* Coordinating Council 2012). The CMS Network also has its own network of dentists who are paid on a fee for services basis.

Healthy Kids competitively bids and contracts its dental plan bids separately from Medicaid. Dental services in Medicaid and *MediKids* are either provided through fee-for-service arrangements or through two managed dental plans in the state, based on where the child lives and which health plan they are enrolled in. In the future, all Medicaid and *MediKids* children will be enrolled in a dental managed care plan. *Healthy Kids* came into compliance with CHIPRA dental requirements on July 1, 2010, when the annual benefit cap was eliminated. The Florida legislature placed limits on FHKC's dental per member, per month rate and, as a result, two of the statewide dental plans did not renew their contracts at that time (four plans had been in the program).

Healthy Kids members are initially auto-assigned to a health plan and a dental plan. Effective October 1, 2009, Florida permits a 90-day "free look" period at the time of initial enrollment and renewal (for the dental plans, this same policy went into effect January 1, 2011 Florida CARTS 2010). The free look period allows the enrollee to change to another plan without providing a reason, and the change becomes effective the first day of the following month. After the free look period, enrollees must meet one of the good-cause exceptions to change plans.[32] *MediKids* and Medicaid enrollees must select a health plan, or, in counties with only one plan, they can select the PCCM program. In both instances, we heard that most advocates in the state advise families to ask their existing providers which plans they participate in, and then to choose those health plans (sometimes requiring a switch for *Healthy Kids* members, who are auto-assigned). Primary care providers are auto-assigned in *Healthy Kids*, but members can go online or call to request a change at any time. Medicaid and *MediKids* enrollees must call the health plan to change their PCP.

B. Quality

Florida has always incorporated quality standards in its managed care contracts. Likely because the state already required extensive reporting on quality measures, Florida voluntarily reported on 12 of the 24 CHIPRA quality measures included in the Federal FY 2010 CARTS reports.[33]

For *KidCare*, participating health plans submit encounter data to the University of Florida College of Medicine's Institute for Child Health Policy (ICHP), which analyzes the data and produces annual reports based on plan encounter data and an administrative interview and medical record reviews. According to ICHP's 2011 annual report, the *KidCare* Title XIX programs exceeded the national Medicaid averages for the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures: access to primary care providers for children ages 12 to 24 months, initiation and continuation of treatment for alcohol and other drug dependence, the use of appropriate medications for children with asthma, and initiation and continuation of attention deficit hyperactivity disorder medication follow-up care. Although *KidCare* performed well on many measures, *KidCare* plans fell below national averages for several indicators of quality of care, such as compliance with the recommended number of dental visits, ongoing prenatal care visits, lead screening tests, testing guidelines for pharyngitis, treatment for upper respiratory infections, and recommended follow-ups for mental health hospitalizations (Nogle and Shenkman 2011).

AHCA also publishes quality measures for all health plan types, including Medicaid and *Healthy Kids* plans on www.floridahealthfinder.gov. Anyone with internet access can view, by county, quality of care indicators and member satisfaction information for each plan and compare plans in his or her county.

Interviewed *KidCare* participating health plans reported viewing the child's primary care provider as the child's medical home; this sentiment was mirrored by other key informants who

[32] Previously, enrollees could switch plans at enrollment, renewal, or during the year for good cause, but they had a shorter period in which to switch.

[33] The Federal Centers for Medicare & Medicaid Services began asking States to voluntarily report on 24 CHIPRA quality measures in the Federal FY 2010 CARTS reports. No State reported all 24 measures; Florida was one of 5 States to report 12 measures; 36 States reported fewer than 12 measures, including 8 States that did not report any of the measures. See Sebelius (2011) for more information.

reported that working with the family in the primary care provider's office is the starting point for care or referrals. The CMS Network utilizes nurses or licensed social workers as care coordinators to act as the hub of the medical home. Health information technology is also in use in Florida. One health plan reported moving to fully implementing electronic medical records (EMRs) to better manage physicians and help them manage their patients, and a provider we met with was already using EMRs in her practice.

Florida, along with its partner state, Illinois, was chosen in early 2010 by the Centers for Medicare & Medicaid Services to receive $11.3 million as a CHIPRA quality demonstration grantee. From 2010 to 2015, the CHIPRA quality grant will fund activities in both states to experiment with and evaluate the use of quality measures for children's health care; support the use of health information technology in measuring and improving children's health; promote and evaluate innovative, provider-based models (medical homes) for delivering children's health care; and implement a quality improvement collaborative focused on improving perinatal and early childhood health care. AHCA manages the CHIPRA quality work group. Informants did raise questions about how reporting will work across different components of *KidCare;* at the time of our visit, the grant was not fully implemented in the state.

Focus Group Findings: Access to Care

Families of children with special health care needs praised the CMS Network for the services and access it provided for their children. Several of these parents also had children without special needs who were enrolled in *Healthy Kids,* and these parents said that by comparison, it is more difficult to access care in *Healthy Kids.* Parents identified challenges with both primary and specialty care access.

The hard thing is that one of my kids is on CMS and the other on a KidCare HMO. Because my son on KidCare regular is 16, pediatricians don't want to take new patients that are 16. I've had a hard time finding someone who would take him. We just found him a doctor and we've been looking since 2010. Our previous pediatrician didn't take this health plan.

A lot of specialty providers around here don't accept HealthyKids. If you are not on CMS, you really can't see anybody [for specialty care]…. That really needs to change. I work in a pediatrician's office and I know first hand that specialists don't take Healthy Kids. If you call the numbers in the book they give you, you call and they always say no. We have to go all the way to Jacksonville [from Tallahassee where the focus group was held, that is 165 miles]. A lot of people are not getting the care they need because they can't drive two or three hours to go see those specialists.

We pay out of pocket for my son to go to a dermatologist because the dermatologist we could get through KidCare was not good. We found a doctor who charges us the Medicare rate – that might not seem like a lot, but when you don't have any money…I am the only one working, my ex-husband is not working. They had to change all of his medications to get them covered. They wouldn't cover the ones the doctor wanted to give him.

C. Access to Care

Plans that participate in *KidCare* must meet contract requirements for network size and content. Key informants think access in *Healthy Kids* is generally good for physical, behavioral, and pharmacy services provided by the health plans and, because there are five health plans in common, there is a some overlap among networks serving *Healthy Kids*, *MediKids*, and Medicaid/M-CHIP enrollees (although they are not identical). Informants said that some subspecialists can be difficult to find (pediatric cardiology was one example offered) depending on where you live, but informants said this is true for whatever kind of insurance you have, not just for *KidCare.* Surveys from ICHP validate that most children in managed care plans receive well-child services: in its 2011 report, 82 percent of families surveyed reported that their child had a well-child visit in the past six months.

Key informants said they had more concerns about those enrolled in the PCCM portions of Medicaid and *MediKids.* Medicaid/M-CHIP and *MediKids* reimburse providers in the PCCM program using Florida Medicaid rates, which are about 57 percent of Medicare. Low reimbursement rates were cited as a factor that affects providers' willingness to participate in these *KidCare* programs. Limited access has also occurred to due to reductions in staffing at Florida's DOH and a push

toward using Federally qualified health centers (FQHCs), which have seen increased traffic since the DOH staff reductions. Key informants said access is a problem in the PCCM program, particularly with speech and physical therapies and pediatric subspecialists, and in rural areas generally.

Consistent access appears to be difficult for families who switch between CHIP and Medicaid (or who are in the *MediPass* PCCM program rather than managed care plans). One problem is that families who transfer from Medicaid to CHIP (or vice versa) are not automatically enrolled in the same health plan, even when their plan participates in both programs. In CHIP, the family is still auto-assigned and might not get the same health plans. As noted earlier in the discussion of benefits, there is a difference in the benefit packages, and families moving from Medicaid to CHIP noted problems, particularly with medications that Medicaid covered but CHIP did not.

Dental access appears to be more problematic in Florida. The dental package is valued at $1,500 and provides comparable services to private insurance. FHKC reports receiving few complaints about any aspect of *Healthy Kids*; from time to time, there have been some complaints about dental health care, typically in the pockets of the state where there are few dentists available. Administrators believe these are primarily provider supply issues and not issues unique to CHIP or Medicaid. Although the state believes the dental network is adequate, key informants and parents in focus groups felt there are areas in the state where access to dentists is problematic (even for privately covered individuals), some dentists in the network limit their panels, which can make it hard to find a dentist who will accept the coverage. Some health plans reported that the plans are not informed which dental plan their member is enrolled in, making it difficult for the health plan to assist a member with dental needs when he or she calls the plan hotline. In ICHP's 2011 report, only 46 percent of families surveyed reported that their children had received dental care in the past six months.

Focus Group Findings: Dental Access

Families with children in two focus groups, either enrolled in *Healthy Kids* or the CMS Network, reported difficulties in finding a dentist who would accept their coverage. They also complained about the services available to their child, saying that the benefit did not cover cleanings or preventive services (although in fact, the benefits do cover these services).

I don't know how to get dental care through KidCare.

The only way you get seen is if you have a problem and it's a dentist who comes into town for a clinic once a week or once every other week. It's like a cattle call with all these people just to get a couple of teeth pulled. To get the kids teeth cleaned, you can't. Getting the teeth pulled was the only thing I could get done. I had to make a lot of calls to find a place to just do that. I just have to be diligent.

We finally found a dentist that would take KidCare and told us what we needed to do; when we went for the appointment, before my child had the services, they presented me a bill for $500. They said, this is only covered for this; KidCare only covers this portion and we don't take that portion. I had to say, sorry, and leave. I can't pay that.

VI. COST SHARING

Healthy Kids was designed to resemble a private insurance product and has always included cost sharing in the form of premiums and copayments (but has never had deductibles or enrollment fees). Table 6 summarizes current cost sharing policies for all *KidCare* programs; most of these policies have remained unchanged since FY 2003–2004 (which was when the premium per family per month increased from $15 to $20 for children in the 151 to 200 percent of the FPL group in *Healthy Kids*). The premiums in the full-pay group have increased over the years; for example, in November 2011, the full-pay premium amount in *MediKids* rose from $159 to the current $196 per

child per month. Only children enrolled in *Healthy Kids* have copayments (see Table 6). In *Healthy Kids*, *MediKids,* and *CMS* Title XXI*,* families pay their premiums to the state's TPA.

Table 6. Cost Sharing in Florida's *KidCare* Programs

Program	Income Level	Premium/Month	Copayments
Healthy Kids[a]	101 – 150% of the FPL	$15/ family	$5: prescription drugs and nonpreventative physician visits $10: inappropriate emergency room visits, emergency transportation, and prescription glasses
	151-200% of the FPL	$20/ family	
Healthy Kids Full Pay	>200% of the FPL	$133/ child	
MediKids	133-150% of the FPL: ages 1-5	$15/ family	NA
	151-200% of the FPL: ages 1-5	$20/ family	
MediKids Full Pay	>200% of the FPL: ages 1-5	$196/ child	NA
Medicaid and M-CHIP	<185% of the FPL: ages 0-1 <133% of the FPL: ages 1-5 <100% of the FPL: ages 6-19	$0	NA

Note: There are no deductibles or enrollment fees in Florida.

[a] Children enrolled in the CMS Network pay family premiums of $15 or $20 based on income, but do not pay copayments.

NA = not applicable.

The TPA sends families a 12-month payment booklet with its notification of coverage letter; enrollment does not officially begin until the month after the first payment is received. To try to make it easier for families to pay their premiums, FHKC has instituted a number of different payment options beyond mailing in the payment (although mail remains an option). These include automatic drafts from their paychecks, checking, or savings accounts; the ability to pay several months (or an entire year) at once; paying online (although there is a $1.50 fee associated with online payment); paying by text (implemented in 2011); paying by telephone; or paying cash at a "Fidelity Express" location (there is a $2.50 convenience fee). The state is looking at smartphone applications for payment (as well as enrollment and renewal) as natural next steps toward offering more technological options to consumers.

Most key informants interviewed reported that cost sharing is not viewed as burdensome. Survey results seem to confirm this: 91 percent of enrolled families surveyed in 2011 for the state's annual *KidCare* evaluation strongly agreed that the premium is worth the peace of mind so that their children can have needed insurance coverage; this percentage did not vary by premium payment level, and has been relatively consistent over the past six years (Nogle and Shenkman 2011; Nogle and Shenkman 2007).

Focus Group Findings: Cost-Sharing

Focus group participants reported mixed views on the affordability of *KidCare:* while some said it was affordable and they knew it was far more affordable than private coverage, many discussed how they struggled to find the money to pay the monthly $15 or $20 premium.

I can barely pay all my copays for my own insurance, so it is really a blessing that I pay $15 a month and nothing for copays for the kids.

We understand that our premium is not even close to what they are paying for the care. We really appreciate it. We don't know what we'd do [without it].

In a focus group with parents of children with special health care needs, some participants said that the premiums were a significant expense for their families, but that they valued coverage for their special needs child enough to pay for it.

The $15 for me is very difficult, because I don't have an extra dime, but I know I can't afford the medication without it and my son has to have coverage. You beg, borrow, steal, let something else go. We don't have cable, we don't have anything extra.… My mom will buy groceries sometimes because I don't have the money to buy groceries, but they are going to have their insurance because I don't have a choice.

Some parents noted that previous spells of uninsurance gave them incentive to pay CHIP premiums on time to maintain coverage.

I paid out of pocket when we were uninsured. I just got the bill paid off for our first baby appointment and he is 19 months old now.

When we were uninsured, my husband had to have surgery … and we went into retirement savings to pay for it. We used all of it to pay the medical bills.

One parent noted the quick consequences for a late payment:
My payment is due on the 7th and I paid it on the 7th, but I got a letter it was late. They can drop you almost automatically. Within a couple of days we were dropped.

Despite these survey findings, state administrators report that the most common reason for children exiting CHIP is nonpayment of premiums, followed by Medicaid enrollment, and then failure to renew. State officials see the disconnect between survey findings and their experience with nonpayment, but are not sure how to address this issue. Eliminating premiums or copayments are not politically viable options, because the legislature believes families should contribute to coverage. Administrators are investigating the possibility of billing families monthly (whether by mail or email) to see if this increases program retention (versus sending a 12-month payment booklet as they do currently). AHCA runs a very small premium assistance program, called "CHIP In," that works with businesses and relatives to try to get donations to pay premiums for families. AHCA is trying to expand the program this year, both in reaching out to more community groups for donations and in trying to expand knowledge about its availability (such as developing a logo). (To date, the families who have been assisted are those who contacted AHCA for help, and then AHCA worked with their relatives directly or sought community partners for help.)

VII. CROWD-OUT

At implementation, crowd-out was not a major concern in Florida primarily because employer-based coverage was unavailable to most low-income residents and, when it was available, was often unaffordable (Harrington and Black 2003). Thus, Florida initially had no waiting period in place for obtaining CHIP coverage; the only requirement was that the child was uninsured at the time of application (Harrington and Black 2003). In 2004, the legislature implemented a six-month waiting

period for those voluntarily canceling other health insurance and stipulated that if children had access to employer-sponsored insurance (ESI), the child would be ineligible for CHIP if the cost of ESI was less than 5 percent of the families' gross income, despite the acknowledgement that surveys indicated that crowd-out was virtually nonexistent in the program (Florida CARTS 2004). This change coincided with a period when the legislature was implementing several restrictions to limit state expenditures. In October 2004, the legislature reduced the waiting period to 60 days, with an effective date of July 2004 (CMS 2010).

Focus Group Findings: Crowd-Out

Crowd-out provisions (the waiting period) were not mentioned as a problem by focus group participants. Several parents mentioned that they had coverage for themselves through an employer, but that the children's coverage through their employer would be too costly.

I have health insurance through [employer] and they pay mine 100 percent but it would be more than my rent to have the kids on my insurance.

It's too expensive for private insurance. The premium (through my employer) is like $180 for you and your kid, and then you have to pay $35 for each doctor's visit, so it doesn't make any sense to get private coverage for your kid.

In 2009, a confluence of factors, including longstanding advocacy of these changes by the Florida *KidCare* coordinating council, passage of CHIPRA, and political support from Governor Crist, led the legislature to simplify some crowd-out provisions. Most importantly, prior to July 2009, applicants who voluntarily cancelled coverage in the previous six months would not be eligible. The Florida legislature reduced the look back time period from six months to 60 days. The penalty period for non-payment of premiums was also reduced from 60 days to 30 days. At the same time, the legislature codified good-cause exemptions, which if applicable, eliminate the waiting period entirely.[34]

FHKC has commissioned annual evaluations of *Healthy Kids* since the program's inception, and household surveys have consistently indicated that crowd-out is not a major problem in *Healthy Kids* (Nogle and Shenkman 2011). Beginning in 2010, evaluators began estimating the extent of crowd-out in *Healthy Kids* using the information submitted at application about access to other insurance, and found that between July 2009 and June 2010, 1.9 percent of children applying for coverage reported having other insurance in the two months before applying. Administrators believe that most parents are afraid to drop coverage for their children, even if only for two months.

VIII. FINANCING

Like Medicaid, CHIP is funded by through a Federal–state partnership. CHIP has a more favorable Federal matching rate than Medicaid: for Federal FY 2011, the Federal government spent about 69 cents for every 31 cents Florida invested in CHIP, compared with Federal spending of 55 cents for every 45 cents the state spends on Medicaid (Florida *KidCare* Coordinating Council 2012; U.S. Department of Health and Human Services 2009).

[34] Good-cause reasons include (1) the cost of participation in an employer-sponsored health benefit plan is greater than 5 percent of the family's income; (2) the parent lost a job that provided employer-sponsored coverage for the child; (3) the parent who had health benefits coverage for the child is deceased; (4) the child has a medical condition that, without medical care, would cause serious disability, loss of function, or death; (5) the employer of the parent canceled health benefits coverage for children; (6) the child's health benefits coverage ended because the child reached the maximum lifetime coverage limit; (7) the child has exhausted coverage under a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation provision; (8) the health benefits coverage does not cover the child's health care needs; or (9) domestic violence led to the loss of coverage.

Historically, Florida has not spent its entire Federal CHIP allotment in most years (Table 7). In Federal FY 2007, Florida lost $20 million from its Federal allocation due to Federal rules on redistributing unspent Federal CHIP funds to states that were projected to have funding shortfalls (Florida *KidCare* Coordinating Council 2012). CHIPRA further reduced the time states have to spend their unused Federal allotment balances to two years (down from three years), which might result in further returns to the Federal government by Florida. Despite the availability of new funds through CHIPRA—the Federal allotment increased by 18 percent from Federal FY 2008 to 2009—key informants said the availability of new Federal funding did not spur the legislature to expand the program.

Table 7. CHIP Allotments and Expenditures (in millions of dollars)

FFY	Federal Allotment	Federal Expenditures	Expenditures as Percentage of Allotment for the Year	Federal Matching Rate
2006	$249.3	$214.1	86	71.22
2007	$296.1	$261.7	88	71.13
2008	$301.7	$272.3	90	69.78
2009	$356.1	$286.4	80	68.78
2010	$356.1	$308.5	87	68.49
2011	$324.9	$357.8	110	68.82
2012	$339.8	$344.2	101	69.23

Source: 2012 Florida *KidCare* Coordinating Council Report.

FFY = Federal fiscal year.

Despite a difficult state budget environment, the CHIP budget has not been threatened in recent years, so there has been no pressure to freeze enrollment or cut eligibility. Key informants believe that the repercussions of the 2004 enrollment freeze—which was instituted because of budget concerns—were so severe that the legislature would be hesitant to cut the CHIP budget again. Moreover, many policies enacted at that time to limit enrollment—such as income documentation and active renewal—remain in effect today, so there is a sense that the right policies are already in place. As noted earlier, Florida has not qualified for CHIPRA bonus funds to date, despite a heavy push by advocates for policy changes to qualify for bonuses.

IX. PREPARATION FOR HEALTH CARE REFORM

At the time of our site visit, Florida was the lead plaintiff in the lawsuit involving 26 states seeking to declare parts of the Affordable Care Act unconstitutional and had rejected an exchange planning grant of $1 million. In 2010, the various state health agencies had begun interagency planning meetings, but those meetings were suspended when the new governor took office in 2011 (although some planning meetings restarted in early 2012). Several key informants anticipated that if the Supreme Court upheld all or most provisions the Affordable Care Act, the legislature would hold a special session in the summer to address exchange issues, but that was speculative. In July 2012, after the Supreme Court decision on the Affordable Care Act, Governor Scott issued a press release stating that Florida will opt out of both the Medicaid expansion and state-run exchanges (Scott 2012). Next steps for the legislature and the state remain uncertain; as of this writing, the state's official position is that it is undecided on the Medicaid expansion and type of exchange it will adopt.

In its 2012 session, the legislature approved funding for an eligibility system replacement valued at $350 million. Although not marketed as helping the state conform to the Affordable Care Act, key informants report that this eligibility system will comply with Affordable Care Act requirements.

Florida's governor requested a 50 percent Federal matching but was granted (and accepted) 90 percent Federal match funds to create this new system. Planning for the eligibility system replacement has already begun; at the time of our visit in spring 2012, DCF had completed a feasibility study that said the current system was at risk of failure due to the age of the mainframe, and that operating costs to maintain the current system were high. The study recommended replacing the system with one that could determine eligibility for all public programs, beginning with Medicaid, then phasing in cash and food assistance programs, as well as the possibility to phase in CHIP; the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); refugee assistance programs; and health insurance exchanges. It has not been decided yet if eligibility determination for CHIP would be done by DCF when the system is in place (currently, DCF determines Medicaid eligibility and FHKC's TPA determines CHIP eligibility), but DCF is planning for that possibility. DCF is working with a steering committee, which includes representatives from all of the other key state agencies (AHCA, FHKC, DOH, and so on) that could be affected by the new system. DCF's current time line calls for the system requirements to be determined by April 2012 to have a procurement document ready by May 2012, to select a vendor to build the system by January 2013, and to have the system ready by October 2013. Although most key informants view these eligibility system upgrades as positive signs toward preparation for reform, they agreed that the state is starting this process belatedly and is likely to have difficulty having it in place by January 2014, when the main provisions of the Affordable Care Act go into effect.

Aside from work on the eligibility system, most key informants said that no decisions on reform-related issues would occur in Florida until after the Supreme Court decision is issued in summer 2012. Many we interviewed hope that *Healthy Kids* continues and, in fact, some think FHKC could be well positioned to take on a bigger role following reform. For example, FHKC is the only group in the state that currently has experience collecting premiums; has already worked with community groups on application assistance programs, a function not unlike the "navigators" referenced in the Affordable Care Act; and, given the general satisfaction with *Healthy Kids*, could be well positioned to offer coverage to adults, allowing children and adults to be in the same health plans. FHKC currently is pursuing a new TPA vendor which can handle the flexibility of health reform. Others suggested that with the new eligibility system at the Medicaid agency, and a large portion of children moving to Medicaid from CHIP because of Affordable Care Act rules, FHKC's role could be less important in the future, calling into question whether and how the state would sustain a separate CHIP program.

FHKC has estimated that about 25 percent of its enrollees (or roughly 64,000 children) would transition to Medicaid under reform (children ages 6 to 18 with family incomes between 100 and 133 percent of the FPL are required to move into Medicaid). Most key informants interviewed agreed that there are access problems in the Medicaid program currently and are very concerned about those problems being exacerbated after reform. One informant reported that the average wait time when calling Medicaid customer service is 45 minutes—compared with 19 seconds for *Healthy Kids*—and that the current call abandonment rate for Medicaid is more than 60 percent. In the past five years, it is estimated that the number of DCF eligibility workers has been trimmed from about 7,000 to about 2,400, with no plans to expand, given the current state budget climate; handling new volume could be a challenge for DCF under reform on a number of fronts. The fiscal impact of covering these additional children under Medicaid will also be significant in a state already concerned about the existing Medicaid budget.

Given the uncertainty of the Affordable Care Act implementation, state officials have delayed planning for outreach efforts post-2013. As the only statewide outreach group in Florida with a wide and varied network of partners, the CKF grantee is expecting to have a major role providing

outreach for the Affordable Care Act. Currently, it is considering what types of education might be needed and how outreach might have to change with Medicaid's expansion, and has been in contact with Enroll America, a national nonprofit organization trying to disseminate information on best practices regarding enrollment.

At the time of our site visit, some key informants suggested that because of the lack of planning, Florida would likely end up in the Federal exchange by default. Advocates think this would benefit the state, as they expect the Federal exchange to be better organized than a state-only exchange. There currently is legislation, passed in 2008, to set up a small-business exchange in the state, but this preceded Federal health reform legislation and is not viewed as a platform on which to build a state exchange, although many think it could be modified to serve this purpose. (At the time of our visit, the state-based small business exchange was not yet operational.) Concerns were raised about the lack of public education and outreach on reform and exchanges, and advocates worry that eligible families might miss out on the opportunity.

Focus Group Findings: Health Reform

Parents who participated in focus groups expressed some excitement, but also fears, about what health reform could bring. All six participants in the likely eligible but unenrolled group said they would welcome the opportunity to have *KidCare* coverage for themselves. Participants in all three focus groups responded positively when asked if they would like it if they could be in the same plans as their children:

It would be important to me to be covered by the same plan as my children. I don't know anything about my insurance, just about my son's.

(If you were covered under the same plan) … it would be less travel, less days off, less confusion, it would be better. We could all just see the same doctor, a family doctor, on the same day.

However, one parent of a child with special health care needs spoke of her concerns about reform:

It feels like it's (health care coverage for adults) going to be what we're dealing with now: that you'll be lucky if you can find someone who will take it, you'll be lucky to get the medications that you need, that…just because you have health insurance, doesn't mean anything…I am relatively healthy, I don't have to go to the doctor. For someone who does have to go who does have chronic problems…if you can't get the help you need, there's no point in having it.

Finally, two parents of children with special health care needs asked the moderator to tell them more about reform, as they did not know about it and would welcome coverage (they were uninsured).

I can't afford cable or a newspaper; can you tell me about that?

State government still publicly opposes the Affordable Care Act, and in November 2012, voters will have the option to add a new amendment to the state's Constitution showing this opposition. Amendment 1 would "prohibit laws or rules from compelling any person or employer to purchase, obtain, or otherwise provide for health care coverage." Although the amendment was proposed before the Supreme Court ruling on the Affordable Care Act, it will remain on the November ballot to allow voters to express their dissent, however even if it passes, it cannot overrule the Supreme Court decision and therefore will have no impact on Florida law (Simms 2012).

X. CONCLUSIONS AND LESSONS

Florida has complied with all of the mandatory requirements of CHIPRA, but few of the optional provisions (Table 8). Informants report that state budget constraints and political will hamper any efforts that would increase program costs or expand enrollment (such as expansion to legally residing pregnant women and children [although this latter group can buy in at full-pay levels to obtain coverage] or offering dental-only coverage to low-income children who have other health insurance).

Table 8. Florida's Compliance with Key Mandatory and Optional CHIPRA Provisions

Provision	Implemented in Florida?
Mandatory CHIPRA provisions	
Mental health parity required for states that include mental health or substance abuse services in their CHIP plans by October 1, 2009	Yes, effective October 1, 2009
Requires states to include dental services in CHIP plans	Yes, effective July 1, 2010
Medicaid citizenship and identity documentation requirements applied to Title XXI, effective January 1, 2010	Yes; implemented for new applications in November 2009, phased in from November 2009 to November 2010 for those renewing coverage
30-day grace period before cancellation of coverage	Yes, effective July 1, 2009
Apply Medicaid prospective payment system to reimburse FQHCs and RHCs effective October 1, 2009	Yes, effective October 1, 2009
Optional CHIPRA provisions	
Option to provide dental-only supplemental coverage for children who otherwise qualify for a state's CHIP program but who have other health insurance without dental benefits	No
Option to cover legal immigrant children and pregnant women in their first 5 years in the United states in Medicaid and CHIP	No
Bonus payments for those implementing five of eight simplifications	Some, but not five of eight
Contingency funds for states exceeding CHIP allotments due to increased enrollment of low-income children	No
$100 million in outreach funding	Three grantees have received CHIPRA outreach funds; FHKC applied twice but was not funded
Quality initiatives, including development of quality measures and a quality demonstration grant program	In the Federal FY 2010 CARTS report, 12 of 24 voluntary quality performance measures were reported Florida's AHCA (Medicaid agency) is a CHIPRA Quality Demonstration Grantee

FQHC = Federally qualified health center; RHC = rural health clinic.

Key findings from the 2012 case study include the following:

- Florida has implemented several simplifications in recent years to try to make family experiences easier, such as administrative verification of income at enrollment and renewal for most families, and a new process intended to simplify the transition from Medicaid to CHIP (whereby CHIP can accept the income reported to Medicaid to determine CHIP eligibility). In focus groups, families who had a child enrolled in the program in the past reported that applying now was easier than it had been before. However, simplification within an administratively complex program can go only so far to improve the program. The disjointed administration of the program affects family experiences, from a lack of consistency in correspondence (being issued a letter that the child was denied Medicaid coverage, when the family had applied for *Healthy Kids* coverage), to paying *Healthy Kids* but

receiving an insurance card that says *United* or *Wellcare,* to different benefits and service delivery systems in Medicaid and CHIP components of *KidCare.*

- The involvement of four separate agencies in *KidCare* administration also compromises the state's ability to operate the programs efficiently. For example, because FHKC is not a public agency, it cannot data match with SSA, which would expedite verification of citizenship. (FHKC proposed appending a file to DCF's data match with SSA, but that has not yet happened.) Moreover, the agencies operate with unique data systems; while they do share data through overnight batch files, the use of separate systems is inefficient, increases the time to coverage for applicants, and creates system gaps. The pursuit of a new information system at DCF that complies with requirements of the Affordable Care Act could improve matters, but it is unclear whether CHIP eligibility determination will transfer to DCF under this scenario. DCF reports the new system will have that capability, but that agency currently does not have the authority to make Title XXI eligibility determinations. At the same time, FHKC has selected a new TPA vendor, and one of its requirements was that the new vendor would have the capability to make eligibility determinations for any insurance available under a future exchange model.

- Although earlier evaluations found that Florida's passive renewal processes virtually eliminated terminations related to paperwork concerns (Harrington and Black 2003), the switch to active renewal coincided with large disenrollments from the program. It is too soon to tell if the administrative renewal approach (using pre-populated forms), implemented in 2011, will improve CHIP renewal rates, but this simplification holds promise for making it easier for families to keep their coverage.

- CHIPRA outreach grants and funding allocated by the FHKC board are the largest sources of outreach funding and are helping to support direct application assistance and other innovative outreach efforts. The state is fortunate to have an organized grantee such as CKF to lead outreach efforts, but the lack of political support in the legislature for outreach activities handicaps outreach efforts. State administrators consistently reported that despite few current state dollars for outreach, "everyone knows" about *KidCare*, but in a focus group with families with children likely eligible but uninsured, a parent reported having never heard of the program.

- Physical health care benefits in *Healthy Kids* are not as comprehensive as in Medicaid, but most key informants feel the benefits package is adequate. In focus groups, families who have switched between Medicaid and CHIP noted that the benefit package differences can be problematic, particularly regarding medications covered by Medicaid but not CHIP. Dental services are difficult to access in *KidCare,* no matter if a child is enrolled in Medicaid or CHIP. This seems like a lesson learned for other states struggling to deal with this population.

- A program dedicated exclusively to children with special healthcare needs has been one of the key successes of the *KidCare* program. Families of children with special health care needs praised the state's CMS Network for its focus on comprehensive services, and the program is well regarded by the legislature.

- Cost sharing is viewed as an important component of supporting the personal responsibility mantra widespread in the state. Annual surveys indicate that cost sharing is affordable for most families, but we heard mixed reports from families that participated in focus groups. Some parents said it was far more affordable than

private coverage, but others talked about struggling to find the $15 or $20 premium money each month. Failure to pay premiums is in the most common reason for program disenrollments, but state administrators say they have no way of assessing whether failure to pay indicates that insurance is not valued by the family, that the premiums is unaffordable to the family, or whether the family has secured other insurance for the child. AHCA has begun a small program to help with premium payments, which it hopes to expand this year.

- Prior to the Supreme Court ruling, the state was taking a wait-and-see approach to health reform; it was investing (with 90 percent Federal match) in a new information technology system for eligibility determinations that would comply with Affordable Care Act requirements, but was generally awaiting the Court's decision to make any other plans. Since the Supreme Court decision, state officials still strongly oppose the Affordable Care Act; the Governor has publicly stated that he hopes national elections in November will undo the law; and he has announced that Florida will not implement the Medicaid expansion or a state-run exchange, although as of this writing the state was officially "undecided" about the expansion and exchange plans.

In summary, *KidCare* is an administratively complex program comprised of four separate programs for children, operated by four agencies, without a single lead agency responsible for its oversight. Separate processes and systems have created fragmented experiences for families on public coverage in Florida. The lack of a unified information system hampers many aspects of the program, such as interagency referrals, correspondence, data matching and verification, and how long it takes to determine eligibility. In addition to a program that can be complicated for a family to understand, the reduction in outreach resources in recent years (compared to the early years of the program) has made it more difficult for eligible families to hear about and to get help applying for the program.

FHKC has made some simplification advances in enrollment and renewal processes in *Healthy Kids*, but without strong support from the legislature, the program has remained stagnant; many of the problems identified during *KidCare*'s early years remain today. Health reform may provide opportunities for these programs to streamline their eligibility systems or revisit their organizational structure, or it may further complicate the program—leaving children vulnerable to coverage gaps.

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APPENDIX A

KEY INFORMANTS

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SITE VISITORS

Mathematica Policy Research
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Victoria Peebles
Vivian Byrd

KEY INFORMANTS: TALLAHASSEE

Agency for Health Care Administration
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Department of Health
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Executive Office of the Governor
Jane Johnson
Michele Tallent

Florida Association of Counties
Heather Wildermuth

Florida Healthy Choices
Rose Naff

Florida Healthy Kids Corporation
Amber Floyd
Fred Knapp
Jennifer Lloyd

Senator Rene Garcia
John Wilson

United Healthcare
Ashley Holton

WellCare Health Plans, Inc.
Susan-Marie Arias
Robert Diaz
Drew Hobby

Xerox Corporation (formerly ACS)
Stephanie Carr
Johnny Gonzalez

KEY INFORMANTS: TAMPA

Florida Covering Kids and Families
Jodi Ray

Florida Next
Steve Freedman

Kids Healthcare Foundation
Melanie Hall

St. Joseph's Hospitals
Marisa Mowat
Tara Hamilton

Tampa Bay KidCare Outreach Project
Michele Pernula

Tampa Family Health Center
Dr. Sylvia Santiago

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APPENDIX B

APPLICATION

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Application & Instructions

Florida KidCare

Child health insurance you can afford!

1-888-540-5437 toll-free • www.floridakidcare.org

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

- **MEDIKIDS:** children ages 1 through 4.
- **HEALTHY KIDS:** children ages 5 through 18.
- **CHILDREN'S MEDICAL SERVICES NETWORK:** children birth through 18 who have special health care needs.
- **MEDICAID:** children birth through 18. A child who has other health insurance may still qualify for Medicaid.

Enrollment. Except for Medicaid, a child must be uninsured before Florida KidCare coverage starts. Some Florida KidCare programs may have limited space, and applications are accepted on a first-come, first-served basis. When MediKids, Healthy Kids and the Children's Medical Services Network are full, enrollment for these programs will close. Medicaid is always open for children who qualify. Florida KidCare does not exclude a child with a pre-existing health condition from coverage.

Ways to Apply. If you applied for Florida KidCare before, call 1-888-540-5437 to update your information by telephone.

- **APPLY ONLINE:** www.floridakidcare.org
- **PAPER APPLICATION:** Please print your answers. Use blue or black ink, fill out the application form and mail it as soon as possible.

APPLICATION INSTRUCTIONS

SECTION 1. PARENT OR GUARDIAN INFORMATION

SOCIAL SECURITY NUMBER (SSN): An adult's SSN on the application is optional. If provided, Florida KidCare uses the SSN for computer matches with other agencies and contractors and it may help speed up your child's application processing.

We will not share your information with the United States Citizenship and Immigration Services (USCIS).

EMPLOYER INFORMATION: Write your work telephone number and employer's name on the application.

If you have more than one job, list each employer's name. If you are self-employed, write "self-employed." If you are not employed, write "unemployed."

SECTION 2. CHILD INFORMATION

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

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

CHILD'S SOCIAL SECURITY NUMBER (SSN): If you have an SSN for your child, write it on the application. SSNs are used to do computer matches with other agencies.

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

CHILD'S CITIZENSHIP: Mark "yes" if your child is a U.S. citizen.

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

- Form I-551 (Green Card, Permanent Resident or Resident Alien Card)
- Form I-94 (Arrival/Departure Record)
- Form I-571 (Travel Authorization)
- Notice of DHS receipt of Form I-589 (Asylum Application), if Cuban or Haitian
- Form I-688B or Form I-766 (Work Authorization Card)
- Passport or Laissez-Passer, including the bearer's name and picture, stamped by the Department of Homeland Security (DHS) showing immigration status or immigrant visa
- Other documentation of status, such as a letter from USCIS, DHS, Immigration Judge or Board of Immigration Appeals Judge
- Letter of eligibility from the Office of Refugee Resettlement

IMPORTANT PUBLIC CHARGE INFORMATION: What you tell us about your child's citizenship status is confidential. Florida KidCare will not share anything you tell us with the USCIS. Information about a parent's immigration status is not needed to apply for Florida KidCare.

A child's enrollment in Florida KidCare does not harm anyone's application for citizenship or legal permanent resident status.

CHILD'S ETHNICITY/RACE: This information is optional and is not used for determining eligibility. If provided, it is used for research and to ensure all people are treated fairly.

Choose A or B and write in the first box in the "Race" section on the application:
A–Hispanic or Latino
B–Not Hispanic or Latino

Choose up to two numbers and write them in the second and third boxes on the application:
1–American Indian or Alaskan Native
2–Asian
3–Black or African American
4–Native Hawaiian or Other Pacific Islander
5–White

DOES YOUR CHILD HAVE HEALTH INSURANCE NOW? Except for Medicaid, a child must be uninsured before Florida KidCare coverage starts.

If your child has health insurance from your employer, check with your employer about your health benefit plan and its requirements before you apply for Florida KidCare. Your plan may allow you to make coverage changes only at certain times in a year.

If your child has other health insurance now, write the name of the health insurance company and the amount you pay for the health insurance each month. If your child only has accident insurance, disability insurance or a discount medical card, then answer "No" to this question.

VOLUNTARY CANCELLATION OF CHILD'S HEALTH INSURANCE: If you canceled your child's health insurance in the last 2 months for one of these reasons, then answer "no" to this question:

1. The cost of an applicant child's health insurance is more than 5% of your family's income.
2. Parent lost a job that provided employer-sponsored coverage for an applicant child.
3. Parent who had the health insurance coverage for an applicant child is deceased.
4. The employer providing the applicant child's coverage canceled the coverage.
5. The applicant child's parent canceled COBRA coverage or the COBRA coverage reached its legal limit.
6. A non-custodial parent dropped the applicant child's coverage.
7. An applicant child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.
8. The coverage does not cover the applicant child's health care needs.
9. The applicant child's coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.
10. Domestic violence led to the loss of coverage for an applicant child.

Florida KidCare

www.floridakidcare.org

MAIL APPLICATION TO: Florida KidCare, P.O. Box 980, Tallahassee, FL 32302-0980.
NEED HELP? If you have questions or need help with your application, call 1-888-540-5437. This is a free call.

READ THE ATTACHED INSTRUCTIONS BEFORE YOU FILL OUT THIS APPLICATION

Section 1. PARENT (OR GUARDIAN) INFORMATION. PLEASE PRINT. "Parent One" is a person the child lives with.

In what language do you prefer to receive mail? ☐ English ☐ Spanish ☐ Haitian Creole

PARENT ONE: Name: First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Social Security Number (SSN) (optional): ___-___-____ E-mail: _____

Address: Number | Street | Apt. Number

City | State | Zip Code | County

Mailing Address: (If different from street address) Number | Street | Apt. Number

City | State | Zip Code | County

Home Telephone: (___)___-____ Cellular Telephone: (___)___-____

Work Telephone: (___)___-____ Name of Employer(s): _____

PARENT TWO: Name: (If living in household) First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Social Security Number (SSN) (optional): ___-___-____

Work Telephone: (___)___-____ Name of Employer(s): _____

SECTION 2. CHILD INFORMATION. Answer the shaded questions below for each child who lives with you. ANSWER ALL QUESTIONS FOR EACH CHILD WHO NEEDS FLORIDA KIDCARE HEALTH INSURANCE. If there are more than three children, attach the information on another sheet of paper. Do not send another application.

CHILD ONE: Name: First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Relationship to Parent One: ☐ Child ☐ Stepchild ☐ Other Relationship to Parent Two: ☐ Child ☐ Stepchild ☐ Other

Are you applying for KidCare for this child? ☐ Yes ☐ No (If no, go to the next child) (see instructions) If yes, Child's SSN: ___-___-____ (see instructions) If none, date SSN applied for: (see instructions) (MM/DD/Year)

U.S. Citizen?: ☐ Yes ☐ No (see instructions) If no, date of entry into the U.S.: (MM/DD/Year) Child's USCIS Number: _____ Race: (optional; see instructions)

Does this child have health insurance now? ☐ Yes ☐ No If yes, is it with: ☐ Medicaid ☐ Medicare ☐ Tri-Care

☐ Other (Insurance company name): _____ Monthly cost: $_____

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? ☐ Yes ☐ No (see instructions) If yes, month/year canceled: _____

CHILD TWO: Name: First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Relationship to Parent One: ☐ Child ☐ Stepchild ☐ Other Relationship to Parent Two: ☐ Child ☐ Stepchild ☐ Other

Are you applying for KidCare for this child? ☐ Yes ☐ No (If no, go to the next child) (see instructions) If yes, Child's SSN: ___-___-____ (see instructions) If none, date SSN applied for: (see instructions) (MM/DD/Year)

U.S. Citizen?: ☐ Yes ☐ No (see instructions) If no, date of entry into the U.S.: (MM/DD/Year) Child's USCIS Number: _____ Race: (optional; see instructions)

Does this child have health insurance now? ☐ Yes ☐ No If yes, is it with: ☐ Medicaid ☐ Medicare ☐ Tri-Care

☐ Other (Insurance company name): _____ Monthly cost: $_____

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? ☐ Yes ☐ No (see instructions) If yes, month/year canceled: _____

CHILD THREE: Name: First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Relationship to Parent One: ☐ Child ☐ Stepchild ☐ Other Relationship to Parent Two: ☐ Child ☐ Stepchild ☐ Other

Are you applying for KidCare for this child? ☐ Yes ☐ No (If no, go to the next child) (see instructions) If yes, Child's SSN: ___-___-____ (see instructions) If none, date SSN applied for: (see instructions) (MM/DD/Year)

U.S. Citizen?: ☐ Yes ☐ No (see instructions) If no, date of entry into the U.S.: (MM/DD/Year) Child's USCIS Number: _____ Race: (optional; see instructions)

Does this child have health insurance now? ☐ Yes ☐ No If yes, is it with: ☐ Medicaid ☐ Medicare ☐ Tri-Care

☐ Other (Insurance company name): _____ Monthly cost: $_____

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? ☐ Yes ☐ No (see instructions) If yes, month/year canceled: _____

FLORIDA KIDCARE DOES NOT EXCLUDE A CHILD WITH A PRE-EXISTING HEALTH CONDITION FROM COVERAGE. To help you get access to specialized care, answer the following questions if your child has a medical, behavioral or other health condition that has lasted or is expected to last at least 12 months.	CHILD ONE		CHILD TWO		CHILD THREE	
	Yes	No	Yes	No	Yes	No
1. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?						
2. Does this child need to get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem?						
3. Does this child need or use more medical care, mental health or educational services than is usual for most children of the same age?						

CF-ES 1853, July 2009

SECTION 3. HOUSEHOLD INFORMATION. Follow the directions on the application.

SECTION 4. MONTHLY INCOME INFORMATION

A "household" means all adults and children who live in your home, except for renters.

SECTION 4a. MONTHLY EARNED INCOME: If you give Social Security Numbers, we may be able to check income electronically. Florida KidCare will let you know if we need proof of income from work. If proof of income from work is needed, Florida KidCare will ask you for readable copies of the following documents:

1. Pay stubs or wage statements—A copy of pay stubs or wage statements from the last four weeks or a letter from your employer that says how much money you earned. If you are self-employed, a copy of a business ledger, records, receipts or a tax statement; OR

2. Most recent W-2 forms (Wage and Tax Statement), OR

3. Most recent federal income tax return.

If no one in your household has work income, write "None" in the first column and go to Section 4b.

SECTION 4b. MONTHLY UNEARNED INCOME: If you give Social Security Numbers, we may be able to check your unearned income electronically. Florida KidCare will let you know if we need proof of unearned income from you or anyone in your household.

Examples of unearned income are social security benefits, disability benefits, unemployment, pensions, workers' compensation, and veteran's benefits.

If no one in your household gets unearned income, write "None" in the first column and go to Section 4c.

SECTION 4c. CHILD SUPPORT RECEIVED: If you get child support payments, Florida KidCare will let you know if we need proof. Examples of child support documents that may be needed are a copy of the court order, a copy of the most recent month's check received for each child, or a written statement from the parent who pays the child support.

SECTION 5 and SECTION 6. Follow the directions on the application.

REMINDERS

Before you send in your application, make sure you have answered the questions and signed and put the date on the application. **The application is not complete without your signature on both lines.**

If proof of income is needed, please send copies—*do not send original documents.*

We will let you know if we need a copy of your child's birth certificate or proof of their identity.

We suggest that you make a copy of your entire application package for your records before you send it. Be sure to put enough postage on the envelope before you mail it.

Mail your application package to:

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

Or send your application by FAX to:
1-866-867-0054

FREQUENTLY ASKED QUESTIONS

How much do I pay each month for coverage?

- There is no charge for Medicaid for children (KidCare Medicaid).
- For other Florida KidCare programs, monthly premiums depend on your household's size and income. Most families pay $15 or $20 a month. If you need to pay more, we will let you know.

If you decide to send a check or money order with the application for the first month's premium, make it payable to Florida KidCare. Do not send cash. If your child (or children) is approved for Medicaid or denied coverage, your premium payment will be refunded.

- You may have to pay small charges or co-payments for some services.
- A child who is a member of a federally recognized American Indian or Alaskan Native tribe may qualify for no-cost Florida KidCare coverage. If your child is an American Indian or Alaskan Native, attach a copy of the front and back sides of your child's tribal identification card or other similar tribal documents. Call 1-888-540-5437 for more information.

What happens after I send in the application?

We will let you know when we receive your application. It will take several weeks to process the application.

First, we will check to see if your children might be eligible for Medicaid. You will receive more information if your children are eligible for Medicaid. If any of your children are eligible for the other Florida KidCare programs, we will let you know. We will contact you if we need more information or a premium payment.

An application will be valid for 120 days after we receive it. We will notify you if the application process is not completed within 120 days for MediKids, Healthy Kids, or the Children's Medical Services Network. To restart the application process, call 1-888-540-5437. An application that is older than 120 days may still be used to determine if your children are eligible for Medicaid.

If enrollment for MediKids, Healthy Kids and the Children's Medical Services Network is closed, we will let you know when we receive your application. We will check to see if your children might be eligible for Medicaid. You will receive more information if your children are eligible for Medicaid. If your children are not eligible for Medicaid, we will notify you. You will need to call 1-888-540-5437 to restart the application process when the programs are open again.

You may ask for a review of a decision if you think the decision was unfair or incorrect. Call toll-free 1-888-540-5437 for information.

When does coverage start?

- **MEDIKIDS AND HEALTHY KIDS:** Coverage starts after the application is approved and your monthly premium is paid. Florida KidCare will let you know when the insurance coverage starts. MediKids and Healthy Kids will not pay for medical services your children received before the coverage starting date.
- **CHILDREN'S MEDICAL SERVICES NETWORK:** Coverage starts after the application is approved and your monthly premium is paid. Florida KidCare will let you know when the insurance coverage starts. Children's Medical Services Network services may start sooner if your child has an emergency health care need. The Children's Medical Services Network also is available to children with special health care needs who qualify for Medicaid.
- **MEDICAID:** If your children qualify for Medicaid, coverage may start in the month your application is received. If you have any unpaid medical bills for your child from the three months before you applied for Medicaid, Medicaid may be able to pay them for you.

IMPORTANT INFORMATION ABOUT MEDICAID

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

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

NEED HELP WITH CHILD SUPPORT? CALL 1-800-622-5437. THIS IS A FREE CALL.

SECTION 3. HOUSEHOLD INFORMATION

1. If anyone in your household PAYS court-ordered child support,
   write in the monthly amount paid: $_____
   Name of person who pays it:_____ *(Your answers may determine deductions and may qualify your child for lower cost coverage.)*
2. If you are applying for an unborn child, what is the expected due date? ☐☐/☐☐/☐☐☐☐ (MM/DD/Year)
3. Do your children have unpaid medical bills from the last three months? ☐ Yes ☐ No

SECTION 4. MONTHLY INCOME WORKSHEET. Follow the directions in each column. Write the amount of income BEFORE taxes and other deductions. Use an extra sheet if necessary. *(see instructions for more information)*

SECTION 4a. Monthly earned income before taxes. If no one in your household has earned income, write "None" in the first column.

Household member name (first and last name)	Is this person in school full time?	Monthly gross income from work (before taxes)	How often paid? (check one)				Monthly income from self-employment
			EVERY WEEK	EVERY 2 WEEKS	2 TIMES A MONTH	ONCE A MONTH	
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ No						

SECTION 4b. Monthly unearned income before taxes. If no one in your household has unearned income, write "None" in the first column.

Household member name (first and last name)	Monthly Social Security benefits (examples: survivor's or disability benefits)	Monthly Supplemental Security Income (SSI) benefits	Monthly income from unemployment	Monthly income from any other source like workers' compensation or investments

SECTION 4c. Child support received. If you get child support payments, write each child's name and the amount of child support you get each month.

Child's name (first and last name)	Monthly amount of child support (if different from court order, explain in Section 4d)	Do you get this full amount every month? If no, explain in Section 4d.
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SECTION 4d. If your normal monthly income is different from the income you listed in Sections 4a, 4b, or 4c, use this space to tell us why. Examples are: overtime that you do not usually get, bonuses, seasonal work, irregular self-employment income, or unpaid child support.

SECTION 5. DAY CARE/AFTER SCHOOL CARE PAYMENTS. List the payments made for day care for a child or a disabled adult so that someone in your household can work. You do not need to send proof of day care payments. If no day care payments are made, write "None" in the first column.

Name of person in care (first and last name)	Monthly amount of day care paid for each person in day care	Person who pays for care
		☐ Parent 1 ☐ Parent 2 ☐ Other
		☐ Parent 1 ☐ Parent 2 ☐ Other
		☐ Parent 1 ☐ Parent 2 ☐ Other

SECTION 6. CERTIFICATION AND AUTHORIZATION.

- I certify that the information provided on this application is true and correct to the best of my knowledge. I understand that if I give information that is not true or if I withhold information and my children get health benefits for which they are not eligible, I can be lawfully punished for fraud.
- I understand that the information will be kept confidential in accordance with Florida and federal law.
- I understand the information I have provided in this application will not be shared with the United States Citizenship and Immigration Services (USCIS).
- I understand the information I provide will be verified, which may include computer file matching and that I may be requested to provide other information.
- I authorize the release of personal, financial, and medical information for determining eligibility, conducting research, or providing health care treatment, payment and administration.
- I attest that the information provided on this application establishes the identity of children under age 16.
- I authorize the use of the E-mail address provided in this application to receive general notifications and reminders about the program.
- I have read and understand my rights and responsibilities as they apply to the Medicaid program.
- I understand that the Florida KidCare program does not discriminate because of race, color, sex, age, disability, religion, nationality or political belief.

YOU MUST SIGN BOTH LINES

SIGNATURE REQUIRED _____ DATE: _____

I certify under penalty of perjury that all the children listed on this application are who I claim them to be.

SIGNATURE REQUIRED _____ DATE: _____

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