The Florida Senate

Interim Project Report 2000-57 *September 1999*

Committee on Health, Aging and Long-Term Care Senator Charlie Clary, Chairman

REVIEW IMPLEMENTATION OF THE FLORIDA KIDCARE ACT

SUMMARY

Florida's Kidcare program was created by the 1998 Legislature to make affordable health insurance available to low and moderate income Florida children. Kidcare is an "umbrella" program that currently includes the following four components: Medicaid for children; Medikids; Florida Healthy Kids; and the CMS network, which includes a behavioral health component.

The administrative structure of the program is complex, although the various agencies implementing the program have worked well together. There have been some start-up problems and implementation has not been as rapid as anticipated. The program has not met the ambitious statewide enrollment goals set by the Legislature, however, the rate of enrollment is accelerating, with waiting lists developing in some counties. The program has a high degree of customer satisfaction and has met its quality and care provision goals.

This report makes ten recommendations to improve the Kidcare program.

BACKGROUND

Purpose and Origin of the Florida Kidcare Program

In response to concerns about the millions of uninsured children in the nation, Congress allotted, through the Balanced Budget Act of 1997 (P.L. 105-33), approximately $40 billion over 10 years to help states expand health insurance coverage to children, either through Medicaid or other health plans. The act, which created Title XXI of the Social Security Act, initially allocates funds to states based on the number of uninsured children in a state and subsequently on the number of low-income children residing in a state. The law allows the use of funds for "targeted low-income children." States may set income eligibility at up to 200 percent of the federal poverty level, or at 50 percentage points above their existing eligibility level as of June 1, 1997, whichever is higher. The federal law allows states to expand coverage for children through: expanding the existing Medicaid program; creating or expanding a separate program specific to the children's initiative, through the use of a federally established "benchmark" coverage plan; or through a combination of these efforts. Children who are eligible for services under Medicaid are specifically prohibited from coverage under the new initiative. Florida was one of three states to have an existing child health insurance program (the Florida Healthy Kids Corporation) grandfathered in as part of the federal act.

In order to receive federal funds under this initiative, a state was required to submit a State Plan for approval by the federal Department of Health and Human Services (HHS). While the states are given broad authority to design programs to meet a state's specific needs, the plan must detail how the state intends to use the funds. The state plan must describe eligibility standards (income and asset limits, age, geography, residency, duration), benefits (which must meet certain federal thresholds), delivery methods, utilization controls, Medicaid eligibility screening, cost-sharing requirements, maintenance-of-effort, outreach efforts, administrative processes, and coordination with other coverage programs. Once the plan is approved, a state can implement its program and start drawing down federal funds.

The Child Health Insurance Program under Title XXI differs from Medicaid in that it allows an enhanced federal match rate, is a block grant from the federal government, and is not an entitlement program. States may impose limited cost sharing (premiums, deductibles, and co-insurance) on the family.

Under the Florida Medicaid program, the match rate is 56 percent federal and 44 percent state funding. The Title XXI program established an enhanced federal match rate of 69 percent federal and 31 percent state funding. An annual appropriation of $270 million in federal funds is available for Florida for the first three years. If the state does not use all of its federal allocation in any year, that money can be "carried forward" for use in the subsequent two years. Title XXI requires that 90 percent of funds be for health insurance coverage for

children. No more than 10 percent of the total amount of federal funding may be expended for outreach, administration, and other costs to administer the program.

Florida has one of the nation's largest uninsured populations. Nearly 23 percent of those below the age of 65 are uninsured. Despite eligibility expansions in the Medicaid program and an increase in enrollment in the Florida Healthy Kids Corporation, it was estimated in 1998 (based on a 1993 Rand study) that more than 823,000 children were uninsured. Of this number, an estimated 293,885 lived in families that were potentially Medicaid eligible due to family income being below 100 percent of the federal poverty level (FPL); 259,336 live in families with income between 101 and 200 percent of FPL; and 270,246 lived in families with income in excess of 200 percent of the federal poverty level. (The current federal poverty level for a family of four is $16,700.)

The Florida Kidcare program was created by the 1998 Legislature in response to the enactment of Title XXI and the large number of uninsured children in the state. The components of Kidcare in the law are:

- Medicaid for children;
- The Medikids program;
- Florida Healthy Kids;
- the Children's Medical Services (CMS) Network; and
- Employer-sponsored dependent coverage (This coverage will not take effect until it is approved by HHS).

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

Medicaid for children included the existing Medicaid program for children with the following eligibility limits: to 185 percent FPL for children 0-1, to 133 percent FPL for children 1-6, to 100 percent FPL for children 6-15, and to 28 percent FPL for children 15-19. The Medicaid portion of Kidcare was also expanded to cover children 15-19 between 28 percent FPL and 100 percent FPL.

Medikids provides the Medicaid benefit package for children age 0-5 who are not otherwise eligible for Medicaid up to 200 percent FPL using the Medicaid administrative infrastructure, paying Medicaid reimbursement rates, and using Medicaid providers, with one exception. Medicaid enrollees may choose MediPass (a primary care case management program) or a Medicaid HMO in any Florida county. Medikids enrollees, however, may only select a MediPass provider in counties with fewer than two Medicaid-participating HMOs.

The Healthy Kids component of Kidcare is administered by the non-profit Florida Healthy Kids Corporation (FHKC), established in s. 624.91, F.S., in existence since 1990. Healthy Kids is the largest non-entitlement component under the Florida Kidcare Act. It operates with a combination of local, state, and federal dollars, and family contributions. Healthy Kids has required counties to contribute funds to support the health insurance subsidy for families since its inception. Currently, counties have a maximum contribution established at 20 percent in the fourth year of operation. The law authorizes the Healthy Kids Corporation Board of Directors to establish a base number of enrollment slots in each county that does require any local match. Currently, each county may enroll 500 children without any local match being required. The law also authorizes the program to vary local matching requirements and enrollment by county, based on a variety of factors which may influence the county's ability to generate local match.

As of August 31, 1999, Healthy Kids was enrolling children in all but 14 Florida counties. In addition to its Title XXI-subsidized population, Healthy Kids also covers children who do not qualify for Title XXI subsidies. As of July 1, 1999, of the total Healthy Kids caseload of approximately 91,000 children, 609 children are non-qualified aliens, children of state employees, or 19 year olds. Healthy Kids receives no federal Title XXI funding for these children.

The CMS Network serves the health care needs of children with serious or chronic physical or developmental conditions who require extensive preventive and maintenance care beyond that required by typically healthy children. The CMS network is a managed system of care that links community-based health care with multi disciplinary, regional, and tertiary pediatric care to provide prevention and early intervention services, primary and specialty care, as well as long term care for medically complex, fragile children. A sub-component, the Behavioral Specialty Care Network, provides behavioral health care services for children with severe mental health problems.

The employer-sponsored dependant coverage component of Kidcare (when implemented) will allow the state to subsidize purchase of children's coverage

through the parent's employer-sponsored group health plan.

Implementation Process

The Florida Kidcare program has been implemented in phases. An initial Child Health Plan (Title XXI) was submitted by the Governor, with approval from the President of the Senate and the Speaker of the House of Representatives, to HHS on December 2, 1997. Phase 1 of the plan included an expansion of the Florida Healthy Kids program to additional counties and more children, and an extension of Medicaid coverage to children ages 15 to 19 with family income between 28 percent FPL and 100 percent FPL. Florida's phase 1 plan was approved on March 5, 1998, and was effective April 1, 1998.

On July 17, 1998, Florida submitted a plan amendment (phase 2) to implement several components of the Kidcare program to provide coverage up to 200 percent FPL for: Medikids, ages 0-5; the Healthy Kids program, ages 5-19; and the CMS network for children who have special physical, developmental, or behavioral health care needs. The plan amendment was approved August 8, 1998, with a retroactive July 1, 1998, effective date.

In December, 1998, Florida submitted another plan amendment to implement the last component (phase 3) of the Kidcare program, the employer-sponsored dependant coverage, for ages 0-19. This coverage was originally scheduled to begin January 1, 1999, however, it is still under negotiation with HHS.

METHODOLOGY

Staff met with and had discussions with staff of the Department of Health (DOH), the Department of Education (DOE), the Agency for Health Care Administration (AHCA), the Department of Children and Family Services (DCF), the Healthy Kids Corporation, the Department of Insurance (DOI), and the Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies. In addition, staff conducted two public forums on Kidcare, one targeted at agency and governmental experts, the second targeted at community and constituent experts on the program. Staff reviewed information from the National Academy for State Health Policy regarding other states' CHIP programs, the results of research projects which have studied Kidcare and Title XXI programs in other states, and the results of surveys and focus groups conducted by local Kidcare agencies. Staff solicited input and recommendations from individuals and groups representing people who use the Kidcare program or who are providers of services under the Kidcare program.

FINDINGS

This interim project is one of several activities designed to review the initial implementation of the Florida Kidcare program. Section 44 of Kidcare's enabling legislation requires AHCA to submit, by January 1 each year, an evaluation of the Kidcare program to the Governor and the Legislature. The agency has contracted with the Institute for Child Health Policy for the required study; preliminary reports were issued in March and August, 1999. Additionally, the Healthy Kids Corporation has contracted for ongoing studies of its operations, as have other entities involved with Kidcare. Likewise, the Kidcare Coordinating Council is in the process of collecting and prioritizing recommendations from its members. Findings and recommendations from these activities will be coming to the Legislature in the months between the release of this report and the beginning of the 2000 legislative session.

Florida created a program which is a combination of Medicaid expansions and public/private partnerships, with a wrap-around system serving children with special health care needs. Florida's Kidcare system is actually four separate programs operated collaboratively: an expanded Healthy Kids Corporation, Medikids, Medicaid for children, and the CMS Network. The combined elements form a predominately privatized program administered in a cooperative fashion by multiple state agencies in combination with private business. The Kidcare program is designed to maximize coverage for eligible children and federal funding participation for Florida, while avoiding the creation of an additional entitlement program under Medicaid.

Kidcare is meeting its philosophical goals. Kidcare is meeting its goal of making affordable health care coverage available to low and moderate income Floridians. Further, it is doing so in a manner which treats low and moderate income Floridians as customers, maximizing participants' sense of personal responsibility and self-worth by allowing them to contribute financially to the health care of their children via premiums and copayments.

Customer satisfaction in Kidcare is high. The results of surveys and focus groups indicate that the goal of a 90 percent satisfaction rate among Kidcare participants was achieved. Preliminary findings (August, 1999) from the legislatively-mandated evaluation of the program were that 91 percent of Medikids and 96 percent of Healthy Kids caregivers were satisfied to very satisfied overall with the program. Another effect of the program, which is reflected in participant comments, is that low-income parents believe that enrollment of their

children in health insurance is the right thing to do, and that children without health insurance are treated like second-class citizens. Parents cite cost as the primary barrier to obtaining traditional coverage. The presence of an insurance product which is easy to obtain, is affordable, and provides ready access to quality medical care is perceived in a very positive manner, and has given low income parents the ability to do, on their own, what they see as the right thing for their children.

Consumers are generally satisfied with the Kidcare benefit package - with one exception: the lack of dental care coverage. There has been some criticism that the benefit package under the Kidcare program is oriented to the needs of adults, and limits the states flexibility to negotiate lower cost benefits. Consumer focus group results indicated that persons participating in the Kidcare program were generally satisfied with the benefit structure offered by the Kidcare program. A key concern, however, is the limited dental care the program provides. Although the benefit package in the Healthy Kids program is quite good, there is a strong sentiment that more adequate dental coverage should be provided. Dental benefits under the Florida Healthy Kids program are provided as a local option and if included, currently only cover cleaning and x-rays.

Kidcare's first year enrollment goals were ambitious; not all of the goals have been achieved. Florida set an ambitious goal for the Kidcare program: enrollment of 254,000 children in the first year of operation. As of the end of June, 1999, 126,000 children were enrolled, giving Florida's program the third highest Title XXI enrollment in the nation, behind New York and California. The enrollment goals were not achieved due to a variety of factors including: limited opportunities for open enrollment, difficulty in getting provider networks in place in some counties, the lack of slots in some counties and negative public perceptions due to early problems in the eligibility/intake system.

Agency staff underestimated the difficulty of converting Healthy Kids Corporation enrollees who were eligible for either Medicaid or Title XXI funding to those sources, which involved requesting income information from the parents of the nearly 50,000 Healthy Kids program participants who were already enrolled when Kidcare took effect, and screening these individuals for Title XXI or Medicaid eligibility. By August, 1999, of the 50,000 participants who were potential conversions, 8,300 families (13,700 children) had still not responded to multiple requests to provide the required income information. The Healthy Kids Corporation has informed these families that failure to submit the information will result in elimination of the subsidy. With the "last chance" letter the corporation enclosed a coupon, good toward a future month's premium.

Enrollment in all the Kidcare components, other than the employer-sponsored component, continues to accelerate. Current projections are for waiting lists to begin to develop by March of 2000.

Slow enrollment has meant that Florida may not be able to use its full share of federal funding from the first year. The Florida Kidcare program served 25,291 eligible Title XXI children and spent a total of $1.7 million ($0.5 million state and $1.2 million federal) from April 1, 1998 through June 30, 1998 (phase 1). A total of 126,000 children were enrolled and $56.4 million ($16.8 million state and $39.6 million federal) was spent in FY 1998-99. The FY 1999-00 budget projects to serve an average monthly caseload of 204,459 children at a total cost of $252.1 million ($76.8 million state and $175.3 million federal).

As a result of the slower than anticipated enrollment, Florida may not spend all of its 1998 federal allotment of $270.2 million within the allowed three years (10/1/98 - 9/30/00). Any unspent federal funds may be allocated to other states. Current estimates reflect that $216.1 million from the first year of federal funding will be spent by 6/30/99. This leaves a balance of $54.1 million which must be spent during the first quarter of FY 2000-01. At current appropriations levels, it is estimated that one-fourth of the federal funds, or $43.8 million, will be spent, leaving a balance of $10.3 million federal funds. The Agency for Health Care Administration estimates that an additional $126.1 million ($38.4 million state and $87.7 million federal) would need to be appropriated in FY 2000-01 to fully fund the unmet need. This will allow the program to serve an estimated additional 81,182 uninsured children under 200 percent of FPL.

Outreach for Kidcare has worked well. Florida's program is held up nationally as a model which has creatively met the needs of a variety of constituencies. The outreach function in Kidcare is the responsibility of the Department of Health, which has made enrolling children in Kidcare a primary goal for the first year. Focus group responses indicate that Kidcare is gaining a high name recognition, and that outreach workers providing personalized assistance for people enrolling have increased the perception that the program is user-friendly.

The outreach component of the program has made applications available at over 5,500 sites throughout Florida. These include schools, county health departments, physician offices, and public assistance offices. Information about the program has been given to over 25,000 community providers and organizations. Training has been provided to staff in over 2,500 sites to assist families with the application. Over 1,000,000 flyers, brochures, posters, and promotional items have been distributed. An extensive public awareness campaign has helped inform the public about Kidcare. Media campaign components included 2,800 television and 3,400 radio advertisements, 250 outdoor boards, 1,150 bus placards, a website with a downloadable application, and a marketing resource guide.

Recently the Department of Health assumed responsibility for the toll free outreach telephone line to alleviate some of the high demand on the Healthy Kids Corporation hotline. This hotline will provide live operator assistance for people with enrollment questions and application requests during the fall enrollment campaigns.

Florida's Kidcare program is complex, which has led to difficulty and confusion for applicants, providers, and professionals. Title XXI offers states significant flexibility in program design and management. States choosing to participate in Title XXI could either expand Medicaid eligibility; create a unique state-designed program, or develop a combination of these two approaches. Across the nation, 23 states developed their Title XXI programs as Medicaid expansions, that is, Medicaid eligibility was expanded to cover additional children who would otherwise not be eligible, using the Medicaid benefit structure, payment rates and provider system. Thirteen states created a stand-alone state-designed program. Ten states designed programs which are a combination of both options.

The downside of the approach Florida took is a complex administrative system. The financial eligibility requirements which differentiate whether an applicant ends up in Healthy Kids, Medikids, or Medicaid vary depending on age. The intake system for each of the components has different administrative requirements, and the component programs have differing levels of enrollment availability. To further complicate matters, in some components, availability and accessibility varies by county, depending on availability of slots, whether the county of residence has been willing or able to raise the required local match, and whether or not a provider network is present. If a component is not currently holding open enrollment, the application may not be acted on until enrollment re-opens. In addition, since components have different service delivery models, a participant may be mandated to join an HMO, or may be allowed to choose between an HMO or a fee-for-service delivery system. If the applicant is a child with special health care needs, he or she will enter an entirely different service delivery system through the CMS Network. Depending on the component in which an individual is enrolled, he or she may be charged a premium, and may pay some deductibles.

The existing different financial eligibility criteria, provider networks, and payment rates in the various components create the potential that, as a child's eligibility factors change over time (age, income or physical status), the child may have to move between components of Kidcare, with a resultant change in provider or benefits. The differences in the components mean that in some cases children in families may be assigned to different programs, with different providers. Approximately 5,000 families in Kidcare have children enrolled in two components of Kidcare; 47 families had children in three components. There is no documentation to date that this situation results in a decrease in family satisfaction or causes these families difficulty in accessing medical care for their children; the Institute for Child Health policy is currently designing a specialized customer survey to assess the effect of enrollment split.

The single page application form and mail-in submission process have been very well received; but the eligibility/intake processing system has been a problem for applicants and medical providers. Prior to 1998, the process for determining Medicaid eligibility for children included two personal visits to the local DCF office, a requirement to produce documentation, and a face-to-face interview lasting on average 90 minutes, during which all members of a family were reviewed for eligibility for all public assistance programs whether the family wanted them or not.

As part of Kidcare implementation, the state agencies administering the program developed a simplified application form which can be mailed in and quickly processed. Parents generally see the new application form as straightforward and easy to complete - a major improvement over other public programs. A major plus in the program is that parents can apply by mail without having to go for a lengthy DCF financial interview.

In its first nine months (October, 1998 thru June, 1999) the Kidcare program received and processed 185,000 applications. Though the application form was simple,

the process it went through once received by Kidcare was not, leading to widespread delays and frustration on the part of applicants. In part, this is due to Florida's program not taking advantage of flexibility under federal law to use a shortcut presumptive eligibility system to get children into the system quickly. Under a presumptive eligibility system an immediate eligibility determination is made by designated entities based on the statements on the application; reported income is verified after the fact. If, on verification, it is discovered that an individual has income which is over the limits for program eligibility, the applicant is taken off the program. Under federal rules for Title XXI, the state is not required to pay back federal funds spent on behalf of an applicant during the verification period.

The choice to not exercise the presumptive eligibility option created a situation in which success was highly dependant on DCF staff being able to process a large volume of applications in a timely fashion. Since federal law prohibited individuals eligible for Medicaid from being served using Title XXI funds, all applicants for that portion of the program were screened for Medicaid eligibility by DCF. During the fall of 1998, the combination of open enrollment and increasing outreach and publicity had produced a large volume of applications for which DCF was unprepared. By November 1998, a backlog of over 20,000 applications developed. The situation was complicated by the lack of an easy way to determine the status of any given application; the DCF non-automated, paper-based systems developed to provide this information became essentially useless as the volume of backlogged applications grew.

Although the mail-in application system was easier for a citizen to access, it did not provide feedback to the person submitting an application that the application had been received, was being processed, or a way a person could inquire about the status of his or her application. Since the program required the applicant to submit a check as advance payment of the first month's premium, applicants became increasingly concerned about their status. The situation began to produce a huge volume of calls from concerned applicants, providers, and others inquiring about the status of applications. Since there was no number to call at DCF, almost all of these calls made their way to the Healthy Kids Corporation member services lines, which had no way of answering questions other than a laborious manual search process involving wading through the paper DCF logs. The Healthy Kids Corporation's 72 incoming lines were constantly jammed with very long wait and hold times, resulting in a high degree of frustration on the part of everyone involved in the process.

In December, 1998, the Healthy Kids Corporation made a unilateral decision to begin sending backlogged applications to its third party administrator for enrollment in the Medikids program, without the required Medicaid eligibility screening. At the same time, DCF began sending backlogged applications out to district offices statewide (rather than only to the four Kidcare processing centers). The backlog immediately began to drop.

Although the backlog has for the most part has been eliminated, the intake and eligibility process, along with the lack of information on the status of an application, have had a negative effect on satisfaction with the program. Despite the fact that the agencies involved have made major improvements in the process, the program's public perception still suffers from the earlier problems.

The Healthy Kids Corporation is opening enrollment to coincide with the start of the 1999-2000 school year. Staff will closely monitor application processing in order to detect as early as possible a repeat of last year's problems relating to application backlogs.

The agencies involved with the program (AHCA, DOH, DCF, DOI, and FHKC) have exhibited an unprecedented level of cooperation in implementing the program. Clearly, Florida's design for Kidcare was one of the most complex in the nation. The design did not designate one agency to be "in charge" of the program with the power or ability to control the activities of the other participant agencies. Kidcare's implementing legislation did however, create the "Kidcare Coordinating Council", an interagency body which includes insurers and families using the program charged with making recommendations concerning implementation and operation of the program. Day-to-day operational decisions and policy changes are made collaboratively by representatives of the Department of Health, the Agency for Health Care Administration, the Department of Children and Families, the Department of Insurance and the Healthy Kids Corporation.

The success of the program has been the direct result of the involved parties' willingness to understand the situation of the other parties, and to cooperate, compromise, and work together to solve programmatic problems as they emerged. In large part the credit for Florida's accomplishment to date should go to the individuals in the leadership positions in each of the agencies, who were able to find solutions to problems, commit their agencies to their part of the solution, and

ensure their agencies' follow-through in making the necessary changes.

Other Issues: A variety of concerns were raised by the Kidcare Coordinating council, providers, advocates, agency staff, and consumers during focus groups and the meetings staff had with people knowledgeable about Kidcare operations:

- Although the program was designed to provide coverage under a single new program name (Kidcare), the program is still not seamless to families and providers. The various categorical demarcations in the program structure are seen as confusing and lead to fragmented coverage for families.

- Simplifying the complicated administrative application processing system is seen as very important. A variety of suggestions have been made, including developing a separate, independent system to process applications and determine eligibility.

- Many feel that the Healthy Kids local match requirement should be eliminated. Currently, each county receives 500 free slots in the Healthy Kids component. After the free slots are used, the county is required to generate up to 20 percent local match for additional enrollees. In some counties, this has proven to be difficult, resulting in waiting lists.

- The 200 percent FPL eligibility limit and the premium requirements are a burden to families with children with special health care needs. Many interested people recommend that premiums be waived for these children. In addition recommendations were made that the state institute a medical expense disregard for families with children having special health care needs so that these families could deduct out-of-pocket medical costs from reported income for eligibility determination purposes.

- Mandatory enrollment in HMOs in the Medikids program prevents families from making their own choice of medical providers and has required children to switch away from current providers.

- The waiting period for reinstatement is seen as unnecessarily punitive. In the current program, being late on a premium payment results in a 60 day suspension from the program. Many individuals point out that in the commercial insurance market, payment of premiums results in immediate reinstatement of coverage.

RECOMMENDATIONS

- Information from preliminary evaluation reports is included in this review. The Legislature should consider the findings and recommendations from the evaluation being conducted by the Institute for Child Health Policy and other studies currently being conducted before finalizing legislation for the 2000 session.

- The structures, relationships, and roles of the Kidcare program are continuing to evolve and the entities administering the program are committed to fixing identified problems as the program matures. Major structural changes could slow down enrollment of eligible children and should not be made at this time. The agencies involved in implementation are urged to continue to improve administrative areas of the program that may be causing children to remain uninsured and focus on meeting enrollment goals.

- The agencies involved in Kidcare implementation should develop a multi-agency, multi-year budget plan which projects enrollment, case load, and expenditures for each agency and each Kidcare program component. This plan should include an explanation of the use of federal funding, as well as any additional information that could help the Legislature determine whether benefits could be expanded (e.g., dental benefits) and how to respond to proposals in Congress to reallocate Title XXI resources.

- The agencies administering Kidcare should recommend ways to shorten the intake/eligibility time frame and should establish, through a formalized inter-agency agreement, processing time lines that each agency is required to follow. In addition, the agencies should develop adminis-trative changes that might be necessary for Kidcare in the future, such as establishing a central outreach function for the entire program, restructuring the intake/eligibility process, and eliminating open enrollment periods. Finally, the agencies should work collaboratively on the preparation of one formal monthly enrollment and expenditure report to be provided to the Governor, Speaker of the House of Representatives, President of the Senate, program stakeholders, and the public.

- Presumptive eligibility should be adopted for the Medicaid, Medikids, CMS, and Behavioral Health Specialty Care components. Presumptive eligibility

may fix problems caused by the current intake/eligibility process, and would provide children with earlier access to primary and preventive care and ensure access to urgent care and care for significant medical problems during the eligibility determination process. The cost of this change is approximately $330,000.

- Consideration should be given to moving children age 0-1 between 185 percent to 200 percent of the federal poverty level from Medikids coverage to Medicaid. In addition, providing Medicaid coverage for pregnant mothers between 185 percent and 200 percent of the federal poverty level should be studied, and agencies should be asked to provide any data indicating health problems of infants who fall into this gap that could have been prevented through access to proper prenatal care.
- To eliminate the problem of children losing their health care coverage due to minor fluctuations in family income, and to ensure that children will have a guaranteed period of coverage in order to ensure continuity of care, 12-month continuous eligibility should be instituted for all Kidcare components. In addition, passive redetermination of eligibility for Medicaid should be developed. The cost of moving to 12-month continuous eligibility under Medicaid is $37,000,000.

- The Legislature should implement a medical expense disregard for the CMS Network to allow families with incomes over 200 percent FPL to deduct the cost of medical care from their incomes for Kidcare eligibility determination purposes.

- The Healthy Kids component now covers some children not eligible for Title XXI funding (aliens, state employees). Possible options, such as coverage for alien children, creating subsidies for state employees falling under the poverty level, or a "buy-in" for family coverage under state employee benefits with a state subsidy, should be analyzed. In addition, consideration should be given to urging Congress to revisit the issue of excluding these groups from coverage. The cost of expanding coverage to undocumented children is estimated to be $10,100,000

- The Kidcare program should be expanded to include dental coverage.

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
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MEMBER OVERSIGHT
Senator Clary and Senator Dawson