

Florida KidCare Coordinating Council

Meeting Minutes – September 11, 2009

Review Draft

Roll Call, Announcements, Approval of Minutes

Dr. Phyllis Sloyer, on behalf of Chair Dr. Ana Viamonte Ros, convened the September 11, 2009, meeting of the KidCare Coordinating Council at 1:05 p.m. Gail Vail called the roll, and a quorum of 27 members or their designated representatives, including late arrivals, was present.

Dr. Sloyer recognized Dr. Barry Setzer, a new member who replaced Dr. Raymond Klein, and Dr. Natalie Carr, who replaced Dr. James McIlwain.

Dr. Sloyer asked if there were corrections to the December 12, 2008 draft meeting minutes. There being none, Mr. Jay Kassack moved adoption, which was seconded by Dr. Steve Freedman. The minutes were adopted as written without objection.

With the members' agreement, Dr. Sloyer announced that the February meeting will be eliminated, reducing the Council's annual meetings from four to three a year — May, August and December.

Federal CHIP Law and Quality Measures

Dr. Sloyer gave an overview of the federal Quality Measure Initiative, indicating that it will have an impact on all of the states. She indicated that the child health quality measures include prenatal and other measures and will apply to Medicaid and CHIP Programs. The goal is to come up with a series of measures to be recommended the national committee for consideration by the Secretary of HHS, by January 2010.

Compliance with the measures is voluntary for the first two years.

The Agency for Healthcare Quality and Research convened a national subcommittee to recommend the measures and at this point the subcommittee has reviewed at least 156 measures for consideration. The committee includes members with expertise in dental care, mental health and chemical dependency, community health centers, children with special health care needs, disparities, and quality measurement. (National and state representatives, and organizational members.)

State representatives have asked that consideration be given to the efforts and costs required for the data collection and the feasibility of collecting certain data

The initial core set of preventive care measures address: (1) presence and duration of health insurance; (2) availability and effectiveness of preventive services, services for acute conditions; services to promote health birth, prevent and treat premature birth, detect presence or risk of conditions that could adversely affect growth and development, and treatments to correct and ameliorate the effects of chronic physical and mental conditions; (3) availability of ambulatory and inpatient care; and (4) taken together, used to estimate overall national quality of health care for children, including children with special health care needs and comparing disparate populations. Specific measures will be available after the subcommittee's next meeting.

Florida KidCare Evaluation

Dr. June Nogle with the University of Florida's Institute for Child Health Policy presented on the Florida KidCare Evaluation for SFY 2007-08. She indicated this was the 10th year report by the Institute. Information collected came from interviews with families, administrative data and finance information.

She discussed the telephone surveys, which were conducted in fall 2008. Newly enrolled families were interviewed in December through February and they were asked about their immediate experience enrolling. Established families were asked about their experience over the past year. Dr. Nogle addressed the unique challenges related to the changeover to the third party application vendor. She indicated that the initial data from the new vendor was inconsistent. There were problems with the data in the last two months of the state fiscal year, so some analyses were limited to a 10-month period.

Some of the highlights Dr. Nogle reviewed were:

- There was an average of 18,600 applications per month representing approximately 364,000 children.
- 43% of children who applied during July 2007 through April 2008 became enrolled in one of the KidCare program components. This represents a 2% increase in applications from the previous year, although it is still down from the 2004-06 period.

- Enrollment trends show a 5% increase from June 2007 to June 2008. This is a reversal of trends, as there have been declines in the last few years.

Dr. Nogle discussed family satisfaction with the enrollment process and indicated that satisfaction is lower this year than prior years, mostly among newly enrolled families. Questions were asked about their application processing experience, access to information through the toll-free number, and access to a customer representative that they felt was helpful. Dr. Nogle indicated that much of this decline could be attributed to the changeover to the new third party application vendor. She noted that this fall, they plan to focus on whether or not the experiences have smoothed out and returned to levels from previous years. This is the first significant drop observed since 2005.

Dr. Viamonte Ros asked if the survey was conducted during the corrective action plan. Rick Robleto commented it was and that some of the data did reflect experiences during the corrective action plan period, which was November to February. Fred Knapp reported that the average speed to answer calls was 22 seconds. Looking forward, Mr. Knapp indicated that there have been no problems with families getting through to the call center.

Dr. St. Petery noted the evaluation did not include Medicaid enrollees, which he considers a shortcoming. Dr. Nogle indicated that Medicaid information would be back in this fall.

Usual Source of Care. Dr. Nogle discussed the data regarding “usual source of care” and Dr. Freedman asked if pre-enrollment presumed they were uninsured. He pointed out that only a 10% improvement in usual source of care says something.

Specialty Care Access. Dr. Nogle talked about access to specialty care. She indicated that most have similar experiences (except CMS) – specialty care is generally well-rated (8.7 out of 10). Overall 43% said it was pretty easy to get specialty care.

Children with Special Health Care Needs. The evaluation showed that that 30% of KidCare enrollees had a special health care need compared to a statewide average of 13%. There is a much greater need in KidCare. A question was asked about why lower percentage for Title XXI as compared to Title XIX components. One explanation might be that children who qualify for Supplemental Security Income (SSI) automatically qualify for Medicaid. Dr. Freedman commented that if about twice as many kids in Title XIX than Title XXI meet the screening criteria, we need to be specific about the networks that are serving these populations to ensure the amount of specialty care needed is available.

Obesity. Dr. Nogle reviewed obesity measures and noted that 13% are obese and this number has been growing (was 8-10% in past years).

Access to Employer Provided Insurance. Families of established enrollees – only a small share (3.2%) have coverage available to the parent through their employer and the premium is affordable. About 12% had access but not at an affordable premium level. Seven percent only had access to individual coverage through their employer.

Gail asked the evaluation addresses adequacy of the benefits. A family may have access to employer-sponsored coverage, but because of the nature of the child’s condition, the benefits may not be adequate to meet the child’s needs. The KidCare law changed this year to identify reasons that are acceptable for voluntary cancellation of coverage, including that the coverage does not cover the child’s health care needs.

Dr. Setzer asked if questions about access to dental care can be added. Dr. Nogle indicated that the main report has much more detail, including information about dental services. The Institute also produces a Technical Appendix (note: a pdf of the KidCare Technical Appendix was emailed to the members after the meeting).

Dr. Carr asked if there are questions about dental care other than an exam (treatments)? Dr. Sloyer clarified that they are looking for the information on the EPSDT measure that talks about treatment, and this is not collected for Title XXI enrollees.

Suggestions for Future Evaluations:

- Include Medicaid enrollees in the sample.
- Include more information comparing urban versus rural respondents.
- Add more questions related to Usual Source of Care:
 - What was your source of care before and after KidCare enrollment?
 - Do you have a doctor or nurse for regular healthcare? Are they at a hospital? A public health department? Do they have a medical home or just a place to go to get episodic care?

- Is there a place that has all of your child's medical records?
- Elicit more information about adequacy/scope of benefits if a family has access to employer-sponsored coverage.
- Drill down more into applications that are NOT approved. Would like to know of those applications (57%), why were they not approved? Suggested they talk with those parents about their experience. And we need to address how we get them back. It would also be helpful to have a denominator to show how big the "hole" is – how many children are uninsured and how many failed to be retained in the program? Are more eligible children going out of the system than are being taken in? (Dr. Nogle indicated they are working with FHK on a proposal to work on focusing on this issue.)
- How many applicants start the process online but don't finish the online application process? Why?
- Is there any way we could not have to wait a year for getting information on the application process? Ms. Merrell indicated she would like to get that information monthly or as often as possible.

PARTNER UPDATES

Agency for Health Care Administration (AHCA)

Gail Hansen presented the August 2009 KidCare Enrollment Report. She indicated that the report includes three months of data. Most program components increased enrollment and have been growing for a few months. Overall, the Title XXI enrollment has gone up continuously since March 2009. Healthy Kids has had continuous increases since April. CMS network has continually had increases in enrollment (this month had a little blip), even through transition with the new third party administrator. MediKids has seen increases in enrollment since January and Medicaid Title XIX increases since April. Overall KidCare enrollment has had continuous increases since October 2008.

September enrollment figures for Medicaid Title XIX show it is up 19,874 to 1,450,881 children. MediKids is up 662, bringing enrollment to 27,868 children. Other program numbers not yet available for September. Dr. Peter Gorski said it would be helpful to have the ratio of the number of enrolled over the total eligibles.

Karen Woodall requested information about uninsured children by county to use as a gauge for measuring success. County level uninsurance data can be unstable and costly to secure adequate sample sizes. Dr. Nogle suggested some possible sources from the U.S. Census Bureau (American Community Survey, small area health insurance estimates).

Ms. Hansen reported on Florida KidCare-related bills enacted during the 2009 Legislative Session, including CS/SB 918, HB 807 and HB 185, as well as the major components of the federal CHIPRA legislation, summaries of which were included in the meeting materials. She also reviewed the FY 2009-10 Florida KidCare Appropriations and the Social Services Estimating Conference. She noted that at the end of FFY 2010, \$196.1 million of Florida's federal funds are likely to revert. Ms. Woodall suggested that the SCHIP federal allotment report should reflect that reversion of funding, otherwise it looks like a mistake. Ms. Hansen clarified that it was just an estimated loss.

(At 2:45 p.m., Dr. Sloyer indicated she had to leave to attend another meeting and asked council member Paul Belcher to chair the council meeting until its conclusion, which he agreed to do.)

Florida Healthy Kids (FHK)

Implementation of SB 918

Fred Knapp provided an update on some of the changes brought about as the result of Senate Bill 918. Mr. Knapp noted that implementation has been a phased approach to meet the July 1 deadline, with some processes brought up as manual processes initially until full automation could be accomplished. Highlights of operational changes include:

- Reduction of the nonpayment penalty from 60 to 30 days. This change involved many "moving parts" (letters, automated scripts, emails, etc.) The TPA also conducted a special call campaign. Approximately 2,300 children were reinstated as a result of this change.
- Voluntary cancellation of insurance. This change required revisions to the application (both hard copy and online). Mr. Knapp noted that two-thirds of families offered full-pay do not take the option. The TPA assessed families who were already on a six-month wait and conducted a special call campaign. Rate change letters were sent to those families eligible for subsidy.

- **Electronic Verification of Income.** Short-term solution begins October 1 – will have a web-based look-up through Equifax (who collects real-time employment information). Pay information can be populated through this service. FHK is running a 90-day pilot to see if this is cost-effective. Data is very clean but it is expensive. Long-term plan is to work on a five-party agreement to data match with the Agency for Workforce Innovation and the Department of Revenue, to use child support, unemployment and wage data for KidCare income verification. Inconsistent pay will be reconciled the same as it is now (on the application). Millicent Pittman asked and received confirmation that clients are notified of this data collection.
- **KidCare Application.** The KidCare partner agencies and Covering Kids and Families have representatives on the application work group. There were many modifications this time due to federal and state law changes and focus group input. The online application is being worked on and will be available on October 6. Mr. Knapp reported that Healthy Kids is printing 1.2 million applications, which will be available to entities for shipping cost only. Rich Robleto added that Healthy Kids tries to help with the cost of getting applications to those in hardship cases. Mr. Knapp also indicated that there are no plans to abolish the current application; the system will support both versions.

In August 20,358 applications were taken in (15,319 on the web; highest amount of web applications taken since the previous September). Paper applications were 3,000 less than last year. Application distribution through schools was not done this year, schools distributed postcards that encourage families to apply for Florida KidCare online.

- **Administrative simplification.** Rich Robleto indicated that an administrative simplification work group started about three months ago. It includes the KidCare partner agencies, advocates, and is chaired by Healthy Kids board member Dr. Judy Schaechter. So far, the committee's focus has been on children transitioning from Medicaid to Title XXI and other retention issues.
- **Transitions between Medicaid and Title XXI.** Mr. Robleto reported that a system change went into effect this week that automatically brings information into the KidCare eligibility system from the Department of Children and Families' (DCF) system. This changes ties into using the federal provision for Express Lane eligibility. Information received from DCF is treated as verified income. Families will just need to make a premium payment to get coverage. Ms. Vail noted that this change operationalizes a long-time council recommendation to accept the income and other necessary eligibility information electronically from DCF for Title XXI eligibility determination. Several council members commended Healthy Kids and DCF for getting this process implemented.
- **Premium payment methods.** Healthy Kids is working on several strategies to make it easier for families to pay premiums, including payroll deduction with large employers and accepting cash payments through approved vendors such as Western Union. The payroll deduction project will start with a pilot with Broward County Schools and will be rolled out to other large employers. Ms. Woodall asked if providers are able to help in notifying families about the need to make a premium payment. Mr. Knapp replied that the Healthy Kids health plans get termination reasons and can use this information the way that Children's Medical Services does to notify families. Roger Hahn indicated that his plan (Vista) gets and uses retention information.

Florida Covering Kids and Families (CKF)

Jodi Ray presented information about Florida Covering Kids and Families outreach efforts. Ms. Ray asked for leads on contacts and outreach ideas.

- **AHCA contract.** CKF is contracted to work in all 67 counties. One task has been to put together some back-to-school press conferences. CKF also works with local communities to build coalitions, conduct training, and provide technical support, including coordinating community efforts to keep from duplicating efforts and bringing resources together. CKF staff encourages back-to-school events and keeps communities apprised of their county enrollment data to help them gauge what is going on in their area. Staff also engages business partners to help their customers and employees know that KidCare exists. Peer match innovation is another component in which partners with successful outreach efforts are matched with those that need assistance.
- **Healthy Kids contract.** CKF oversees and provides ongoing technical assistance to a set of community partners who have a contract with Healthy Kids to do a specific set of outreach strategies (levels I, II and III). The contract also includes an initiative to reach out to schools via a pilot project with an urban and a rural school to provide application assistance using school district information and direct outreach to school districts.

Linda Merrell asked about funds that communities are putting into outreach locally. Ms. Ray indicated that her report does not represent all of the efforts being made by the KidCare partners or by communities around the state.

Family Report

Gail Vail distributed information on behalf of The Family Café and presented a request from Lori Fahey: What is the next step available for families with children who have preexisting conditions and cannot afford to pay for employer-sponsored coverage. She is for recommendations for options for two specific families in that situation. Cover Florida was suggested as an option. Gail also noted that Blue Cross/Blue Shield of Florida has a web site called Health Care Resources for Floridians in Need, and a link to the site is available from the Florida KidCare web site.

Discussion and planning for the 2010 Annual Report and Recommendations

Ms. Vail reviewed the council's 2009 recommendations and summarized their status (table attached). She indicated that by the December meeting, we should have a better sense of the federal health care reform proposals and how they might affect the council's 2010 recommendations.

Other Council Business

MOTION: Linda Merrell made a motion to reactivate the dental work group. The motion was seconded and adopted without objection.

Ms. Vail requested forms for continued membership on the council.

Mr. Belcher announced the next meeting will be held December 4, 2009.

The meeting adjourned at 3:51 pm.

Status of 2009 Florida KidCare Coordinating Council Recommendations

Recommendation	Legislative/Administrative Status	Additional Information
Outreach		
<p>Restore and fund Florida KidCare community coordination, retention efforts, and health, family education and utilization functions to reach uninsured children. Marketing should be conducted for the entire Florida KidCare program. Family advocates should be included in the planning, development and implementation of the marketing messages and open enrollment announcements. In addition, provide funding for marketing and education for hard-to-reach and special populations. Evaluate marketing efforts to measure value received for expenditures. Marketing should be research-based to assure appropriate language and literacy needs of Florida's diverse population.</p>	<p>Not adopted at the state level</p> <p><i>Marketing for the entire Florida KidCare program adopted in CS/SB 918</i></p>	<ul style="list-style-type: none"> ▪ The University of South Florida's Covering Kids and Families project was awarded almost \$1 million by the federal government for outreach activities. The KidCare partner agencies provided input on the grant application and will have an active role in providing information and assisting Covering Kids with its project. A second round of federal funding also may be available for outreach. ▪ With existing funds Florida Healthy Kids sponsored community outreach partnerships, purchased KidCare applications and promotional items that are available for the cost of shipping only, and promoted its "Act-Out for Health" contest among Florida schools. The corporation also has a marketing and outreach committee.
Eligibility and Enrollment		
<p>Extend full pay Florida KidCare coverage to infants from birth with family incomes above the established federal income eligibility for SCHIP.</p>	<p>CS/SB 918 provides that children with family income above 200% FPL may participate in the Florida KidCare program.</p>	<p>The provision was not implemented for infants under age 1 with family incomes above 200% FPL; additional statutory clarification and possibly funding needed.</p>
<p>Fully fund the Florida KidCare program, including its annualization needs and projected growth needs in order to maximize the use of Florida's SCHIP federal funds and include all eligible uninsured children.</p>	<p>Legislature funded KidCare Estimating Conference projections.</p>	<ul style="list-style-type: none"> ▪ Additional federal funds are available – state match required; reimbursement based on enrollment. ▪ The estimating conference projections did not account for all potentially eligible but uninsured children. National estimate of Florida's uninsured children: approximately 18% (785,000 children, all income levels).
<p>Reinstate and implement presumptive eligibility for all Florida KidCare program components.</p>	<p>Not adopted</p>	<p>This is one of eight eligibility simplification efforts which, if adopted, would count towards a state's eligibility for CHIPRA bonus payments.</p>
<p>Increase Medicaid eligibility for children ages 1 through 18 to 150% of the federal poverty level.</p>	<p>Not adopted</p>	<p>Federal health care reform may affect this issue. Bills provide for Medicaid coverage up to 133% FPL (Senate) or up to 150% FPL (House).</p>
<p>Using Title XXI funding, adopt a seamless system for children with special health care needs by moving to Medicaid CMS Network (CMSN) eligible children with family incomes up to at least the established federal income eligibility for SCHIP.</p>	<p>Not adopted</p>	
<p>Implement the state option Family Opportunity Act pursuant to the Deficit Reduction Act of 2005.</p>	<p>Not adopted</p>	

Recommendation	Legislative/Administrative Status	Additional Information
Allow coverage in all of the Florida KidCare program components for children not eligible for Title XIX or Title XXI up to at least the established federal income eligibility for SCHIP, using only state and local funds with no federal match.	Not adopted at the state level	Federal health care reform may affect this issue
Implement a medical income disregard for children with catastrophic illnesses who would otherwise qualify for Title XXI subsidies.	Not adopted at the state level	Federal health care reform may affect this issue
Continuity of Care and Retention		
To promote smooth transitions between Florida KidCare program components and prevent breaks in coverage, when a child has been determined as over-income for Medicaid by the Department of Children and Families (DCF), accept the income and other necessary eligibility information electronically from DCF for Title XXI eligibility determination.	<i>Adopted administratively</i>	
Provide a two-month grace period of premiums for children who transition from Medicaid to Title XXI and institute presumptive eligibility for Title XXI for children who lose Medicaid to reduce gaps in coverage.	Not adopted	
Implement 12 months of continuous eligibility for all Florida KidCare components.	Not adopted	This is one of eight eligibility simplification efforts which, if adopted, would count towards a state's eligibility for CHIPRA bonus payments.
Make loss of employer-sponsored coverage due to cost in excess of 5% of a family's income a qualifying reason for subsidized Florida KidCare coverage if a child would otherwise meet the program's eligibility requirements.	<i>Adopted as part of CS/SB 918</i>	
Administrative Efficiency		
Revise the earned and unearned income documentation requirements to first use electronic verification of income and then require other written income documentation only if the electronic verification does not substantiate the family's income.	<i>Adopted as part of CS/SB 918</i>	Implementation in process
Use a single entity to determine a child's financial eligibility for all of the Florida KidCare program components.	Not adopted	This issue is under review by the Administrative Simplification Committee.

Recommendation	Legislative/Administrative Status	Additional Information
Provider Reimbursement		
Increase Medicaid reimbursement for physician and dental services provided to children ages 0 to 21, in order to ensure access to care. For physicians, the reimbursement should be increased at least to Medicare levels. For dentists, since there is no Medicare benchmark, the reimbursement should be appropriate to ensure access to care.	Not adopted	
Federal Recommendations		
SCHIP Reauthorization. Reauthorize and increase SCHIP funding commensurate with each state's current growth projections.	<i>CHIPRA was enacted in February 2009</i>	
Redistribution Formula. Continue the current process of the redistribution formula to ensure all eligible states receive redistribution funds.		CHIPRA provides for bonus payment based on enrollment and implementation of 5 of 8 eligibility simplification efforts. A contingency fund also is available if state spending exceeds CHIP allotments in a given year due to increased enrollment.
Outreach. Recognize and support efforts on the federal level to fund outreach and enrollment efforts in the states.	<i>Included in federal CHIPRA law</i>	CHIPRA provided \$100 million in outreach grant funding.
Legal Immigrant and Public Employees' Children. Provide sufficient federal funding and remove enrollment impediments from Title XXI of the Social Security Act, such as restrictions on public employees' children and immigrant children who would otherwise qualify for subsidies.	<i>Federal CHIPRA law gives states the option to implement Title XXI-funded coverage for legal immigrant children and pregnant women during their first five years in the U.S. No provisions were implemented to allow federal funding for public employees' children.</i>	Option not adopted at the state level
Age Eligibility. Increase the age limit for the State Children's Health Insurance Program to age 21.	Not included in federal CHIPRA law	Federal health care reform may affect this issue
Vaccines for Children. Allow the Title XIX Vaccines for Children program to be used for the State Children's Health Insurance Program.	Not included in federal CHIPRA law	
Medicaid Documentation Requirements. Repeal the Medicaid citizenship and identity documentation requirements.	Not included in federal CHIPRA law. The federal CHIPRA law extends Medicaid citizenship and identity requirements to Title XXI. The law provides options for states to comply with the requirements.	<ul style="list-style-type: none"> ▪ Florida's KidCare application incorporates attestation of identity for children under age 16. ▪ Planned use of DOH Office of Vital Statistics data to verify citizenship for children born in the state.

Recommendation	Legislative/Administrative Status	Additional Information
Uniform Adoption of Best Practices. Require the Department of Health and Human Services (DHHS) to establish a streamlined and simplified enrollment system to be applied to all states, incorporating best practices and lessons learned from Medicaid and SCHIP (e.g., no asset test; self-attestation; automatic enroll if eligible for other federally-funded, means-tested programs; presumptive eligibility.)	No requirement for all states to adopt this provision	There are provisions in the CHIPRA law which tie bonus payments to states that adopt simplified enrollment procedures, but no requirement for uniform adoption of best practices.
Medicaid Buy-In. Support initiatives to allow families who are ineligible due to income to buy into the Medicaid program.		Federal health care reform may affect this issue.