

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): FLORIDA KIDCARE PROGRAM

SCHIP Program Type:

- Medicaid SCHIP Expansion Only
 Separate SCHIP Program Only
 Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

Contact Person/Title: Bob Sharpe, Deputy Secretary for Medicaid

Address: 2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Phone: (850) 488-3560

Fax: (850) 488-2520

Email: sharpeb@fdhc.state.fl.us

Submission Date: February 28, 2002

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility - NC

B. Enrollment process

Florida Healthy Kids

Beginning in August 2001, Healthy Kids implemented an on-line application pilot project. Five diverse sites across the state were selected to participate. Trained volunteers are utilized to assist families with completing an application from a secure, password protected web site, which is then electronically submitted to Healthy Kids for processing. A paper application is also produced for the parent to sign and return to Healthy Kids by mail. This pilot project will be evaluated before determining whether or not to launch the program on a wider scale.

Behavioral Health Network (BNet)

The Department of Children and Families' Behavioral Health Network (BNet) enrollment process has been enhanced with better defined coordination and sharing of enrollment data and enrollment procedures between the BNet state program office and Children's Medical Services Network. Additionally, BNet applicants are now given written notification regarding the parent/guardian obligations to support the plan of treatment and to keep the child enrolled in the Florida KidCare Program through timely payment of premiums. Written notifications regarding the status of eligibility/ineligibility for the BNet program were also added.

MediKids

The 2000 Florida Legislature passed new language in the Florida KidCare Act to allow MediKids to do mandatory provider assignments for those children eligible for the MediKids program who do not select a provider voluntarily. On November 8, 2000, the Health Care Financing Administration approved mandatory assignment. The Agency for Health Care Administration submitted a request to its fiscal agent to update the MediKids system to accommodate mandatory assignment, and mandatory assignment has recently been implemented.

Prior to implementation, mandatory assignment was done manually, and on an emergency basis only. For instance, when a Health Maintenance Organization (HMO) closed in a county, we mandatorily assigned all MediKids enrolled children to a new provider as of the first of the month following termination of services by the exiting HMO. The MediKids program office then sent letters to each affected family to inform them of the change. Families were given the opportunity to call, toll-free, to change the assignment if they were displeased.

Mandatory assignment is a valuable tool that helps children get enrolled in the program more quickly and assures access to health care services upon enrollment. Parents of children who appear to be MediKids eligible, are sent letters during the application process asking them to call a toll-free telephone number and select either a Health Maintenance Organization (HMO) or a MediPass provider, depending upon the county of residence. Prior to mandatory assignment, children could remain in a pending status for months if the parents did not call to select a provider, because without a provider selection on the information system, the eligibility file will not run. Mandatory assignment does not eliminate choice from the provider choice process; it ensures that the child moves to coverage more quickly. There is no lock-in restriction; therefore, parents always have the option to select another managed care provider if they so wish.

Now that the system has been coded to perform the mandatory assignment process automatically, it works as follows. As part of the application process, the Agency's fiscal agent sends parents of MediKids eligible children a letter advising them that they must select either an HMO or a MediPass provider as part of the application process. The letter tells them that if they do not select a provider within 10 days, a provider will be chosen for them. As before, if they do not like the assigned provider, they can call and change the selection.

C. Presumptive eligibility

Although the 2000 Florida Legislature authorized the KidCare program to enroll children in Medicaid who are presumptively eligible, the Agency believes that it is not fiscally feasible to implement presumptive eligibility at this time, given a growing budget shortfall.

D. Continuous eligibility

There are no changes in the continuous eligibility policy. Under the Medicaid program, children under age 5 are covered for 12 months; children 5-19 are covered for 6 months. Children enrolled in SCHIP KidCare programs are covered for 6 months.

E. Outreach/marketing campaigns - The Florida Department of Health (DOH) is responsible for outreach to the KidCare population. During FFY 2000-01, several changes were made to outreach efforts. Highlights of the changes are as follows:

- The message of the multi-media campaign was revised. Prior to September 2000, DOH concentrated on an approach to marketing that conveyed the concept of health insurance providing “one less worry” for parents. This message was a strong motivator designed to satisfy parents’ expressed preference for detail, clear messages, and information about whether both parents could work and what benefits KidCare provided. Ease of application and no face-to-face interview requirements were also important messages. During the fall and winter of 2000, DOH developed a new message for marketing materials, focusing on the value of having health insurance and preventative health care. New television and radio “value ads” were developed to emphasize the value of health care and to encourage use of health care services. The value ads encourage families to maintain and access health care coverage for their children, to improve retention of KidCare enrollees.
- The Department of Health worked to establish links with community partners to help direct potentially eligible children to the program. A major component of this effort was the development of “dental partner kits.” The kits contain information targeted to dental providers, posters and brochures, applications, and information on how to order additional materials. Kits were provided to dentists across the state working with children potentially eligible for KidCare. The kits were developed with information from focus groups. The focus groups also indicated a need for simple information to be repeated often, outreach to these groups to be repeated at least annually, and all materials to be provided in an easy-to-use manner.
- The KidCare Program continued to expand the KidCare website at www.floridakidcare.org so that community and interagency partners can access information on the program, including extensive application and enrollment data, for use in evaluating and targeting efforts to identify underserved children.
- New strategies were developed to target immigrant populations. Strategies included: 1) contracting with the Rural Women’s Health Project for the development of KidCare outreach materials targeted to rural Hispanic male heads of household, that include original musical compositions promoting the KidCare program in music styles that are popular with the targeted population. Focus group research showed that the male head of household in Hispanic families was often the individual who made the decision on whether the family would apply for KidCare for their children, thus outreach materials were developed to specifically appeal to Hispanic males; 2) contracting with the Department of Children and Families to provide funding to volunteer agencies in six counties in Florida serving a high volume of refugees, to provide outreach to these populations and get those who are eligible enrolled in services. DOH contracted with the University of South Florida Lawton and Rhea Chiles Center for Healthy Mothers and Babies to continue to administer the KidCare Refugee and Entrant outreach project. The project is moving into its second phase, which includes the production of refugee service directories listing resources for refugees and entrants.
- DOH has begun efforts to track the number of KidCare applications received as a result of the consolidated application process with the subsidized child care centers. Systems at child care centers have been modified so that a KidCare

application can be printed for the family at the time of the family's application for subsidized child care. After reading a brochure on rights and responsibilities, the applicant can sign and mail the KidCare application immediately, which contains a numerical code for tracking purposes.

- DOH has developed a poster and newsprint ad specifically targeting the American Indian/Alaskan Native (AI/AN) population, encouraging families to call a toll-free number for more information regarding eligibility. Children who are members of federally recognized tribes might be eligible for a waiver of KidCare premiums and co-payments. The DOH's website was also modified to include a message advising AI/AN families about the existence of the premium waiver.
- In an effort to reach eligible families where they live and congregate, KidCare is concentrating on targeting faith-based organizations. A staggered, targeted effort began in November 2001. KidCare partner kits geared towards African American families include a poster and brochure designed for faith-based organizations, as well as a KidCare application and a personalized letter of encouragement from the Secretary of Health.
- In November 2000, Healthy Kids began an Enrollment Retention Pilot Project. This project is aimed at new enrollees to the program. Each month half of the new enrollees received a phone call that welcomed them to the program. This phone call also gave Healthy Kids an opportunity to reiterate the payment policies, check mailing addresses and ensure that the enrollee had received their membership information from their health plan. Initial results of this pilot project indicate that enrollees who received a phone call remained enrolled in Healthy Kids for longer periods of time than enrollees who did not receive phone calls.
- As a result of the pilot project's success, Healthy Kids decided to expand this pilot to include all new enrollees and to add an annual follow-up phone call to the enrollee during their birthday month. A vendor was selected for this project in October and the contract was implemented on November 1, 2001.
- Behavioral Health Specialty Care Network changed its name to Behavioral Health Network (BNet). A new logo was created as well and all outreach materials were updated with the new name.

F. Eligibility determination process- NC

G. Eligibility redetermination process

The clinical eligibility redetermination time period for the Behavioral Health Network was changed from every 6 months to every 12 months to be consistent with CMSN. The redetermination process was not changed.

A simplified eligibility redetermination process for Medicaid is in the development stage for implementation at a future date.

H. Benefit structure

For the FHKC, a new comprehensive dental package was added to the standard benefit package by the 2000 Florida Legislature and was implemented effective February 1, 2001. As reported in the 2000 annual report, this benefit was initially limited only to counties who contributed a minimum of \$4,000 in local match funds. This provision was removed by the 2001 Legislature and Healthy Kids is working to complete the statewide implementation of this benefit by the statutory deadline of June 30, 2002. Subsidized enrollees in Healthy Kids will receive this new benefit without any additional costs or co-payments.

I. Cost-sharing policies - NC

J. Crowd-out policies - NC

K. Delivery system - NC

L. Coordination with other programs (especially private insurance and Medicaid) - NC

M. Screen and enroll process - NC

N. Application

The Florida KidCare Collaboration Project coordinated revisions from the KidCare partners on the KidCare application and application brochure. Some of the changes included: (1) removing the absent parent information from the application, (2) clarifying that a parent's social security number is not required, (3) placing a tracking number on the applications to assist in identifying effective outreach and enrollment strategies, and (4) explaining the Native American/Alaskan Native cost sharing exemption. (Copy Attached.)

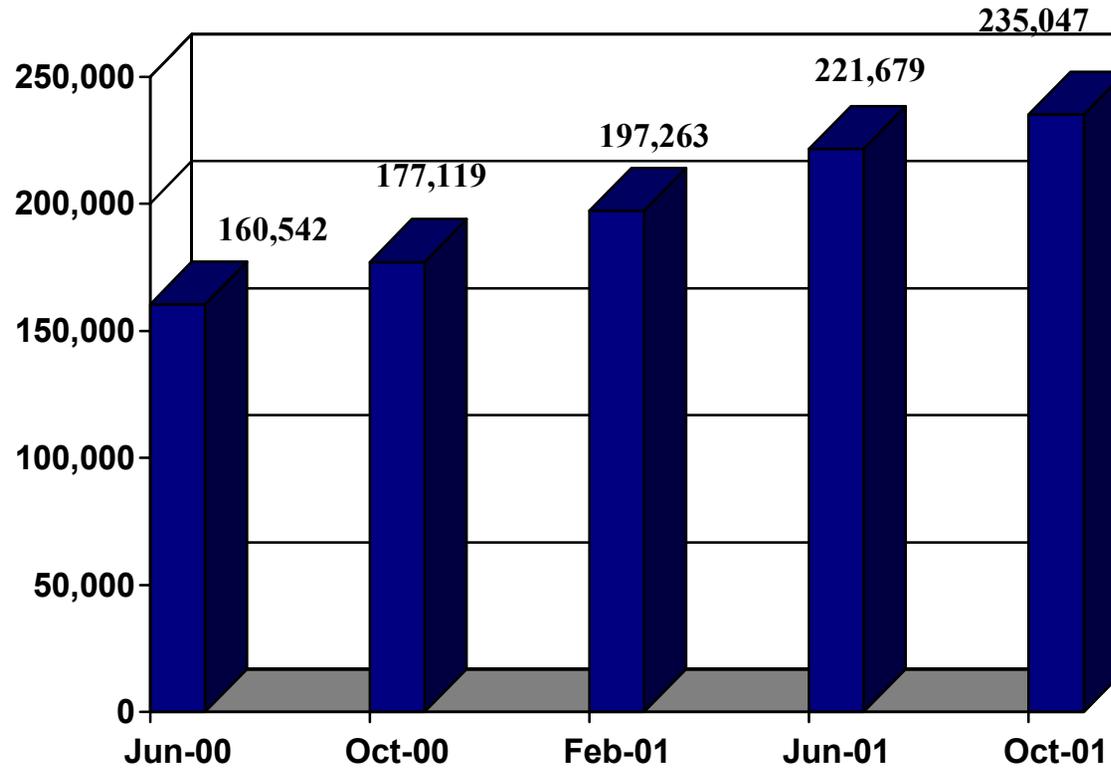
O. Other

Third Party Premium Payment Assistance – The KidCare Coordinating Council recommended allowing third parties to pay premiums on behalf of families in need. The KidCare partners recently launched a 6-month pilot initiative to implement this

recommendation. The pilot is currently restricted to several counties in the Florida Panhandle area.

Special Projects –The Department of Health has contracted with 11 organizations across the state to conduct KidCare outreach targeting underserved populations, including the Hispanic, African-American, and Haitian Creole populations. The contracts are for a period of one year and support the Department’s goal of reducing racial and ethnic disparities in access to health care.

Figure 1 - Florida Title XXI Enrollment



1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

The number of children covered through SCHIP was 235,047 as of September 30, 2001. Growth in coverage is depicted in Figure 1 above. The unduplicated count of children ever served is higher due to turnover.

The Florida KidCare program continued to see tremendous growth in the past federal fiscal year. There were 57,928 more children covered through KidCare at the end of federal fiscal year 2001 as compared to the end of the prior year. This represents a 33% increase. In addition, Medicaid enrollment for the same age population increased substantially. As of September 30, 2001, there were 994,771 Title XIX children receiving services, as compared to 898,677 on September 30, 2000.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The number of uninsured children is lower than in 1997, the year prior to SCHIP implementation, according to the 2000 Current Population Survey (CPS). The percent of children uninsured dropped in 1998 and 1999 even with population growth, but began to rise again in 2000. The 2000 increase represents about 26 percent of the growth in the number of children residing in Florida. The number of children in Florida grew 246,000 between the 1999 and 2000 CPS. Sixteen percent of Florida's children remain uninsured according to the 2000 CPS. The number of children privately insured according to the 2000 CPS continued to increase, but the percent of children with private coverage dropped slightly from the prior year to 59.5 percent, which is still higher than the 56.3 percent found in the 1997 CPS.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

The number of children (minus expansion paid for under Title XXI) enrolled in Medicaid as of September 30, 2001 was 994,771. This represents an increase of 96,094 children over the September 2000 enrollment figure of 898,677. A large proportion of the growth in Medicaid enrollment among children is attributable to simplified SCHIP application procedures and the SCHIP outreach initiative. For the period of 10/1/00 through 9/30/01, the FHKC received 169,732 applications representing 301,917 children.

During federal FY 00-01, 109,178 children were enrolled in Medicaid as a result of their mailed KidCare applications or about three

fourths of applications referred to the Department of Children and Families (DCF). DCF is responsible for Medicaid eligibility determination. Five percent of the children referred to DCF during the state's fiscal year did not become enrolled in any KidCare component.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

The number of uninsured children under 18 is lower than 1997, the year prior to SCHIP implementation. Rates dropped in 1998 and 1999. However, the number of uninsured has started to increase again. The increase represents 26% of the growth in the number children in Florida. 16 percent of children under 18 remained uninsured. The number of children privately insured continues to grow.

The number of children covered through SCHIP was 235,047 as of October 2001. Growth in coverage is depicted in Figure 1 above. The unduplicated count of children ever served is higher due to turnover.

The Florida KidCare program has seen tremendous growth in the past federal fiscal year. There were 57,928 more children covered through KidCare at the end of federal fiscal year 2001 as compared to the end of the prior year. This represents a 33% increase. In addition, Medicaid enrollment for the same age population increased substantially.

Describe the data source and method used to derive this information.

Agency monthly reports, FHK's reports to the Agency, and the Florida On-line Recipient Integrated Data Access (FLORIDA) system.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

 X No, skip to 1.3

Although this number has not been changed, Healthy Kids will initiate its own survey of the number of uninsured children in Florida. Previous surveys or studies of the uninsured in the state did not focus primarily on the number of uninsured children. The planned Healthy Kids survey by the University of Florida's Institute for Child Health Policy will provide a better estimate of the current number and family income levels of uninsured children.

_____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: If no new data are available or no new studies have been conducted since what was reported in the March 2001 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to reducing the Number of Uninsured Children		
Percentage increase in uninsured children who enroll in the Florida KidCare program.	The reduction in the percentage of uninsured children.	Data Sources: Current Population Survey Methodology: Difference in percentage in CPS from 1999 to 2000. Progress Summary: The number of uninsured children grew between 1999 and 2000, but is still lower than before SCHIP implementation. The rate is 16%

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>in the 2000 CPS as compared to 20% in the 1999 CPS. The number of children with employer-based insurance also increased. Florida has difficulty in estimating impacts, as it is a growth state. The number of children in Florida grew by 637,000 between the 1997 and the 2000 CPS. Since enrollment in employer-sponsored plans grew by 200,000, it is possible to assume that the number of uninsured children could be up to 57,000 more without the increase in Medicaid and SCHIP. Instead of a drop in the percentage of uninsured, there would have been an increase. In looking at these figures it should be noted that the CPS traditionally under-represents Medicaid, and thus the numbers cannot be compared to enrollment changes in the program. All children entering SCHIP</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		are uninsured. The percent who had any insurance in the prior year varied by program. The highest of the Title XXI programs was MediKids where approximately 33% had access to employer based insurance at entrance to the program. The percent with access to coverage is higher. However, parents report being unable to purchase the coverage as the cost is too high and would represent approximately 8% of their income. Under KidCare this amount exceeds the amount of the federal cap (5%) on income on both premiums and co-payments.
Objectives Related to SCHIP Enrollment		
Percentage increase in uninsured children	Reduction in the percentage of uninsured children.	Data Sources: Enrollment reports.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
uninsured children who enroll in the Florida KidCare program.		<p>Methodology: Enrollment at the end of the prior year.</p> <p>Progress Summary: Enrollment is 53% higher for Title XXI over 1998 enrollment for the fiscal year. Although enrollment grew in all components of KidCare except the Medicaid 15-19 age group (which was anticipated given expansion of regular Medicaid), the legislative targets were not met. As of June 30, 2000, only 53% of enrollment targets were met. Healthy Kids met 53% of its target. MediKids met 72% of the target and CMS met 76% of the target.</p> <p>As of September 30, 2001, 235,047 children were enrolled in Title XXI. Of this total, Florida Healthy Kids had 191,091, MediKids had 26,992, CMS had 6,535, Medicaid for Teens had 9,566, Medicaid for Babies (0-1) had 863. Title XIX</p>

<p>Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)</p>	<p>(2) Performance Goals for each Strategic Objective</p>	<p>(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)</p>
		<p>Medicaid had 994,771 children enrolled as of September 30, 2001.</p>
<p>Objectives Related to Increasing Medicaid Enrollment</p>		
<p>Percentage increase in children who are eligible for Medicaid and enroll.</p>	<p>Reduce the number of children who are ineligible for Medicaid.</p>	<p>Data Sources: KidCare mailed enrollment forms compared to Medicaid enrollment files as reported in the Florida KidCare Evaluation 2001</p> <p>Methodology: KidCare applications are matched to Medicaid enrollment files by the KidCare evaluators.</p> <p>Progress Summary: During the federal fiscal year, 109,178 children (or about three fourths) became eligible for Medicaid based on their KidCare application</p>

<p>Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)</p>	<p>(2) Performance Goals for each Strategic Objective</p>	<p>(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)</p>
<p>Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)</p>		
<p>Increase in the number of children who have access to health care coverage.</p>	<p>The increase in the percentage of children with a usual source of care.</p>	<p>Data Sources Florida KidCare Evaluation 2001</p> <p>Methodology: Follow-up surveys after enrollment for 12 months.</p> <p>Progress Summary: Overall, 85% of families whose children were newly enrolled in KidCare reported that they have one person they think of as their child’s personal doctor or nurse. This percentage improved for post-enrollment. Over 90% of families whose children were in the program 12 months or longer indicated they had a usual source of care. There were differences between</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		programs in terms of the ease of finding a personal doctor they were “happy with.” About 69% of Medicaid families said it was “not a problem.” Sixty-eight percent of MediKids families, 83% of CMS families, and 73% of Healthy Kids families said finding a doctor they were “happy with” was not a problem.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
Improve the health status of children in Florida.	A. Percent of parents with children enrolled in the Florida KidCare program that report improved health status of their children. B. Percent of children	Data Sources: Florida KidCare Evaluation 2001 Methodology: Telephone interview information from a representative sample of parents of new enrollees from each KidCare program are compared using the Child Health Questionnaire (CHQ-28) to parental reports at 12-month follow-up. The CHQ-28 is a standardized instrument designed to comprehensively measure the

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	<p>who have age appropriate immunizations.</p>	<p>physical and psychosocial well being of children. Comparisons are also made in terms of compliance with American Academy of Pediatrics guidelines for well child visits. Rates for ambulatory sensitive conditions are done based on comparison of hospital records for children.</p> <p>Progress Summary: A. There was no change in health status. Over 90% of families with enrollees age 2 and over were compliant with AAP recommendations for well child visits. Compliance with AAP guidelines was compared between new enrollees and those who had been enrolled 12 months or more. Results show that compliance following KidCare enrollment is very good, and is comparable to compliance prior to enrollment.</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)												
		<p>B. Parents also reported on their child's immunization status. Overall compliance increased as follows:</p> <table data-bbox="974 760 1545 922"> <thead> <tr> <th>Immunization rate</th> <th>FY 1999</th> <th>FY 2001</th> </tr> </thead> <tbody> <tr> <td>DPT</td> <td>92%</td> <td>87%</td> </tr> <tr> <td>Polio</td> <td>90%</td> <td>96%</td> </tr> <tr> <td>MMR</td> <td>86%</td> <td>97%</td> </tr> </tbody> </table> <p>Overall, compliance for Varicella improved from 63% to 68%, but was noted only for the MediKids and Medicaid programs. Improvements were noted for Hepatitis for Healthy Kids only.</p>	Immunization rate	FY 1999	FY 2001	DPT	92%	87%	Polio	90%	96%	MMR	86%	97%
Immunization rate	FY 1999	FY 2001												
DPT	92%	87%												
Polio	90%	96%												
MMR	86%	97%												
OTHER OBJECTIVES														

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Maximize consumer health plan choices.	<p>A. Increase the number of Healthy Kids program sites with multiple health plan choices for families.</p> <p>B. Percent of MediKids families making a choice of health care provider within 14 days.</p> <p>C. Percent of children with special health care needs who select the CMS network.</p>	<p>A. Data Sources: Healthy Kids documents</p> <p>Progress Summary:</p> <p>During the federal fiscal year 2000-2001, the number of sites offering multiple health plans did not increase, as enrollment did not meet the threshold for considering multiple plans. However, beginning October 1, 2001, one additional county will implement health plan choice and two other counties that had already had multiple health plans added additional plan choices due to enrollment growth.</p> <p>Also, the number of sites receiving the new dental program also increased during the federal fiscal year from 0 sites in 1999-2000 to 23 sites by 9/30/01. All sites with the new dental program provide a choice of three dental insurers.</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		B. and C. Methodology: NC Progress Summary: NC

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Florida is continuing to make changes to its outreach, re-enrollment and enrollment processes to ensure that those eligible to enroll are enrolled to the extent that funds are available.

1.5 Discuss your State’s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

Florida is monitoring a variety of issues to improve performance of KidCare. Please refer to the attached reports that discuss these issues. Issues covered include family satisfaction with Healthy Kids in Florida’s rural counties, an analysis of disenrollees, actual vs. expected health care use among Healthy Kids enrollees, consequences of state policies for SCHIP enrollment, and the impact of program eligibility and benefit package changes in KidCare.

Highlights of findings are as follows:

Almost 15% of KidCare families in rural areas of Florida report that their children are seen by a public health department, community health center or a clinic operated by a hospital or HMO, rather than a private physician. This is in contrast to previous studies that show about 10% of families in non-rural areas, which have clinics as their usual source of care. Thus, a higher percentage of children in rural areas have clinics as their usual source of care when compared to children in non-rural areas.

25% of parents of children in rural areas report that it is a problem getting a referral for their child to see a specialist. This may be due to lack of provider availability in rural areas.

Overall family satisfaction with the KidCare program is high. Approximately 95% of the parents surveyed reported that they were very-satisfied to satisfied with the benefits in the KidCare program. The majority of parents (65%) stated that they were able to choose their child's primary care provider. And over 90% of the parents reported that the quality of care their child received through KidCare was "excellent" to "good".

The most common reason cited for disenrolling from KidCare was cancellation due to non-payment of premium (49%). This disproportionately occurred among African-American families when compared to white families. Interestingly, only 9% of respondents indicated that they disenrolled from the program because of the amount of the monthly premium, and 86% of the group cancelled due to non-payment of premium reapplied to the program. The next most common reason for disenrollment (26%) was that they had obtained other health insurance.

It was determined that the most KidCare children in HMOs are receiving the expected care based on their diagnoses, and that, overall, there is neither an underuse nor overuse of health care services by KidCare children in the managed care system.

In a study of the SCHIP programs of four states it was noted that a significant proportion of enrollees in Florida (50%) were enrolled in the program for at least two years after initial enrollment. This contrasted with the other three states, which had more than 50 percent disenroll after relatively short periods of enrollment, and most did not return.

This result may be due to Florida's "continuous eligibility", which allows for slight fluctuations in family income during the enrollment, and passive re-enrollment policies.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Please refer to Section 2.8, C.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

- *Florida KidCare Evaluation 2001* Report by the Institute for Child Health Policy
- Evaluation of the Behavioral Health Specialty Care Network, July 2001, by the Louis de la Parte Florida Mental Health Institute
- FHKC Local Match Assessment – November 2000
- Analysis of Disenrollees of the Florida Healthy Kids Program
- Family Satisfaction with the Healthy Kids Program: Florida's Rural Counties
- The Actual vs. Expected Health Care Use Among Healthy Kids Enrollees
- The Consequences of States' Policies for SCHIP Disenrollment
- Disenrollment and Re-enrollment Patterns in a Children's Health Insurance Program: The Impact of Program Eligibility and Benefits Package Changes
- Review of Care Provided to Florida Healthy Kids Enrollees – Duval County (This is one of 12 studies for different Florida counties).
- Immigration Study by the Institute for Child Health Policy

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: NA

- A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.
- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?
____ Number of adults
____ Number of children
- C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: NA

- A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).
- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?
____ Number of adults
____ Number of children

2.3 Crowd-out:

- A. How do you define crowd-out in your SCHIP program?

Crowd out is defined as families dropping existing coverage on their dependant children to enroll in SCHIP.

B. How do you monitor and measure whether crowd-out is occurring?

The applicant must be uninsured at time of application. Families are counseled when they call the DOH KidCare hotline that if they have coverage, they are not eligible for the program. As part of the state's annual evaluation, a sample of new enrollees is asked to what extent they had coverage in the year prior to enrollment. They are also questioned as to whether or not they had access to employer-based coverage, and the cost of such coverage.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Relatively few new enrollees have access to employer-based coverage. In 2000, in the 12 months preceding program entry, 15% had access. While the rate rose to 24% in 2001, the average cost for families to purchase the coverage would exceed 8% of their income. The SCHIP statute mandates that families not spend more than 5% for both coverage and other out-of-pocket expenses such as co-pays and deductibles.

More detailed information on crowd-out is contained in the attached Florida KidCare Evaluation 2001 Report by the Institute for Child Health Policy.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Stringent tests do not appear to be needed. The data indicate that simply requiring families to be uninsured is adequate to prevent crowd-out. The number of children obtaining employer-sponsored coverage has grown faster than the rate of population growth since the inception of SCHIP according to current population information.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Florida has determined that a targeted approach to outreach is necessary in order to reach the underserved populations in the state. Florida KidCare has several intensive outreach projects that are aimed at special populations. They include: Free and Reduced Lunch Eligibility Project, 4C Project, Refugee and Entrant Project, Reaching Hispanic Migrant Project, Linking Florida KidCare and Subsidized Child Care Project, American Indian Outreach, Project AYUDO, and the Florida KidCare Outreach Special Projects. Health Fairs are utilized in conjunction with other outreach efforts/marketing items such as posters.

Schools continue to be listed by enrollees as the main source through which new enrollees received KidCare information. Word-of-mouth through family and friends was the second most frequently listed source of information. For children with special needs, health care providers play an important role in informing children about KidCare.

Also, the use of ad hoc groups in producing outreach materials that are “family friendly” to diverse underserved populations has helped to eliminate barriers to enrolling Hispanic and migrant farm worker children, as well as children in other underserved populations.

Effectiveness has been measured in the following ways:

In order to ensure that KidCare outreach staff use the most effective targeting strategies possible, we conduct ongoing internal evaluation activities in addition to the overall KidCare evaluation commissioned by the Agency for Health Care Administration. Some of the most important are:

- Evaluations of the impact of media campaigns on call center and application volume. Our most recent studies indicated an increase in both calls and applications over similar time periods without a campaign. Comparing Oct-Dec 2000 with Oct-Dec 1999, there was an increase of 89.8% in calls and 517.5% in applications. Comparing Jan-March 2001 with Jan-March 2000 there was an increase of 206% in calls and 49.1% in applications in areas targeted by the media campaign.
- Evaluation of “partner kits” sent to some of our key provider partners to determine whether this approach increases support for the program among providers. Our latest study indicated that:
 1. 89.3% of the respondents had previously heard about the KidCare Program, and one-quarter of those had heard of KidCare from the local KidCare representatives.
 2. Less than 25% of their provider clients were uninsured.
 3. 85.5% of the providers were going to tell their families about KidCare.

4. Almost all the respondents (95.3%) wrote that they would display the materials in visible areas.
- Evaluation of consumer feedback from the KidCare website, added in May 1999. Respondents are asking for an email address where they can ask questions and get answers, for provider lists, and for an on-line application.
 - Evaluation of a special Childcare/KidCare Link initiative in which Florida's 27-child care central agencies assist families to apply for child care subsidies and KidCare simultaneously. The program began in December 2000 in 24 of the central agencies, and through May 2001, 719 children had applied through the process, and 390 had become enrolled (there is typically a 6-8 week lag between application receipt and appearance on the enrollment files used for this study).
 - Evaluation of a special 6-month initiative in Miami using child care center workers to encourage immigrant families to enroll their children in KidCare. The project will continue through December 2002. The most recent analysis reveals that in spite of hand-selecting centers serving immigrants, with input from the local child care experts, and with the direct work being done by a Hispanic woman and a Haitian women, and with the promise of cash incentives to centers for children who apply, the center directors are reluctant to participate in this effort because of fear that families may be identified and somehow brought to the attention of authorities. It was discovered that many of the children in these centers were insured to begin with, but that fewer than half of staff children were insured.
 - Evaluation of a series of mail and telephone strategies to re-enroll children who lost Medicaid coverage in the process of de-linking welfare and health insurance. It was determined that mailing a personalized invitation was far more cost-effective than any of the telephone methods used, in terms of both actual yield and cost per re-enrollee. This special mailing yielded a 7% re-enrollment rate, which is about twice what could be expected from a general mailout.
 - A series of special studies is now being designed to work out the details of connecting an application for free and reduced school lunch with applying for KidCare. The technical aspects of the proposed processes are now being pilot tested with a variety of school districts, and an interdepartmental workgroup is handling the necessary contracts and memoranda of understanding necessary to conduct these studies with ample protection for families. In addition to formal evaluation studies, DOH works with local projects to provide them with information needed to judge how to direct their activities. For example, DOH posts monthly information tracking:

1. The reasons for which applications are automatically put in a pending file, by county.
2. Application yield for locally designed focused outreach efforts, through use of a special coding system and monthly report by county. This system has just been enhanced to allow use of pre-numbered sets of applications in lieu of hand-coding applications.
3. Children being enrolled through the child care and the central agency link projects.
4. Language preference of applicants.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Analysis of data from the new enrollee survey conducted as part of the KidCare evaluation by the Institute of Child Health Policy indicated:

- White families (52%) and those in the “other” racial category (56%) were more likely than African-American families (50%) to learn about the program through the schools. The schools also were an important source of information for those who were Hispanic, with 59% of Hispanics versus 50% of non-Hispanics learning about KidCare in this way. African-Americans were significantly more likely than non-African-Americans or families in the “other” racial category to learn about the program through family and friends (48% versus 43% and 25% respectively). Similarly, family and friends were reported as a source of information for 47% of Hispanics versus 43% of non-Hispanics.
- Another important source of information was television, particularly for families who are African-American. About 30% of African-American families reported hearing about KidCare from television versus 24% of white families. Hispanics also were significantly more likely than non-Hispanics to report hearing about KidCare from television (31% versus 24% respectively). Social service agencies played a role in informing families about KidCare with 19% to 28% of families reporting social service agencies as an information source. White or non-Hispanic families were significantly more likely than non-white or Hispanic families to report hearing about KidCare from social service agencies. White families also were significantly more likely than African-American families or families in the “other” racial category to hear about KidCare through newspapers (19% versus 17% and 13% respectively).

C. Which methods best reached which populations? How have you measured effectiveness?

(See response in Section A. above).

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

For the Behavioral Health Network (BNet), there are full-time dedicated staff at the state program office and BNet district coordinators who coordinate the delivery of behavioral health services under the Title XXI KidCare Behavioral Health Network. The District Coordinators also contract with local behavioral health providers who employ credentialed clinicians known as Behavioral Health Liaisons. These individuals are responsible for the day-to-day management of each of the local network enrollment pools, which includes outreach activities, case management, and assistance to families in resolving issues that might affect continued enrollment.

In November 2000, Healthy Kids began a pilot project aimed at retaining its enrollees in the program for longer periods of time. The Enrollment Retention project began as a pilot project of the Healthy Kids call center. Call center representatives made phone calls to half of each month's new enrollees. The representatives took this opportunity to review the child's account, payment policies and benefits with the parent. It was an opportunity to also confirm whether or not the child had received his/her membership cards and handbook from the health plan.

An initial evaluation of this pilot project indicated that those families who received a phone call from the retention project remained enrolled in the program an average of five months longer than those new enrollees who did not receive a phone call. But, as a result of these initial findings, Healthy Kids decided to make this a permanent feature. A vendor was selected to conduct these phone calls with all new enrollees as well as an annual follow-up phone call during the enrollee's birthday month beginning November 1, 2001.

Because of these steps the rate of disenrollment for 2001 declined from 2000--20.7% for MediKids, 13.9% for Healthy Kids and 17.8% for CMS. Forty-two percent of the disenrollment was due to failure to pay the premium. The rate was higher at 56% for Healthy Kids as compared to MediKids, which was 36%. Almost 21% of Healthy Kids and CMS children who disenroll, re-enroll. However, when disenrolled they must wait 60 days to re-enroll following cancellation for failure to pay premium, as required by state law. The rate for re-enrollment for MediKids is lower at 8.3%.

Medicaid does not have any premium requirements and the primary reason for disenrollment given by individuals contacted in a disenrollee survey was difficulty with the renewal process (40%). The second most cited reason for disenrollment (34%) was income ineligibility. For Healthy Kids enrollees, the reasons given for disenrollment were: obtained other insurance for their children (27%), and cancelled due to non-payment of premium (24%). For MediKid disenrollees, 34% reported that their income was too high, 31% were cancelled due to non-payment of premium, and 23% obtained other insurance as the top disenrollment reasons. 43% of CMS disenrollees indicated that they were cancelled due to non-payment of premium, and 24% obtained another policy. Contact rates for those no longer in the program are lower than for the other surveys, as individuals are harder to reach and much less willing to participate in the survey when located.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

Follow-up by caseworkers/outreach workers

- Renewal reminder notices to all families
- Targeted mailing to selected populations, specify population
- Information campaigns
- Simplification of re-enrollment process, please describe - Families who disenroll but are still eligible may call the Healthy Kids Corporation to request reinstatement without filling out a new application. There may be a waiting period due to a state law requiring a minimum 60-day wait for reinstatements following non-payment of the monthly premium.
- Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe - The Healthy Kids Corporation conducts ongoing family satisfaction surveys and conducts specific disenrollment surveys throughout the year.
- Other, please explain - CMS Nurse Care Coordinators call ALL parents who appear on the termination list if they are terminating as a result of non-payment. This reminds them to pay their premium.

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

There are no renewal reminder notices sent to Title XIX families.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

The most effective method for retaining enrollment is to make the process as simple and as family-friendly as possible. 40% of families who did not renew Medicaid coverage after their eligibility period ended gave difficulty with the renewal process as the reason. They also tended to be less satisfied with the Medicaid program when compared to those who did not terminate.

In the Behavioral Health Network the most effective measure has been regular contact by case managers to ensure compliance with a plan of care, timely resolution of issues, and timely submission of premium payments.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured)? Describe the data source and method used to derive this information.

Overall, 57.5% of those contacted in a disenrollee telephone survey, conducted by the Institute for Child Health Policy (IHP) as part of the annual evaluation, did not get other insurance for their children. The most frequent source of coverage for those who did get coverage

was private insurance. The rate was 77% for Medicaid, 86% for MediKids and 87% for Healthy Kids. 17% of the Medicaid enrollees reported that they had either re-enrolled in Medicaid or secured another KidCare plan. Less than 20% of the remainder reported re-enrolling or enrolling in another KidCare program.

2.6 Coordination between SCHIP and Medicaid:

Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Medicaid and SCHIP have a joint application for coverage of children. All Florida KidCare programs use the same simplified application for the initial determination for eligibility for Title XXI. Each program uses a separate eligibility determination and redetermination process to address each program's unique, statutorily mandated, eligibility standards. However, for SCHIP programs, household size and income may be counted differently, and SCHIP does not have any income disregards. Information on the application with regard to income for SCHIP is self-attested. Random audits of applications are conducted in order to verify eligibility in SCHIP programs. Income is verified for Medicaid applications by matching with Department of Labor income files but verification does not delay the eligibility determination.

When a family applies for health coverage with the simplified application to the KidCare program, the application is screened for potential Medicaid eligibility. If a child is potentially eligible for Medicaid, the application is electronically sent to the Department of Children and Families (DCF) for a Medicaid eligibility determination. If parents also are applying for other benefits (such as food stamps or TANF), a separate application and process is used. The parents can become eligible for Medicaid through that process, which is more complex and involves asset and income verification and a face-to-face interview. The redetermination process for Medicaid mirrors the application process – a blank form is sent to the family for completion. The SCHIP renewal is passive. The redetermination process for Medicaid mirrors the application process – a blank form is sent to the family for completion.

Only 22% of those referred to DCF were not found to be Medicaid eligible, and only 9% of those referred to DCF did not end up enrolled in any component of KidCare.

A. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

If a child is no longer eligible for Medicaid and the family has not previously applied for coverage under KidCare, the family is given a Form 2092 to attach to a completed KidCare application form. The form must be mailed to the Healthy Kids Corporation for processing. It takes approximately 6-8 weeks to process the application for coverage

If a child becomes ineligible for Medicaid and DCF has an application form, DCF will send the application and form 2092 to the Healthy Kids Corporation showing the child's ineligibility for Medicaid, and the Healthy Kids Corporation can then process the application.

If a child had a previous KidCare account and is no longer eligible for Medicaid and the family has a KidCare application on file with the Healthy Kids Corporation, the application can be processed for the other SCHIP programs if the parent calls the Healthy Kids Corporation and indicates that the coverage is about to end. Staff can then verify the Medicaid ending date and work to ensure a timely transition.

If a child becomes eligible for Medicaid while enrolled in one of the other KidCare programs, the family may call and report an income change. The information will be updated by the Corporation and referred to the Department of Children and Families for a Medicaid determination. When eligibility is determined, the child will move to Medicaid via electronic interchange. Additionally, all accounts are reviewed each month for active Medicaid enrollment, so if a family enrolls in Medicaid, its SCHIP account will be cancelled at the end of the month.

B. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

All children enrolled in Florida KidCare use managed care delivery systems. However, managed care plans and physician networks differ from one KidCare program to another. For instance, the FHKC currently contracts with 13 different commercially licensed health plans to deliver services to enrollees throughout the state. Many of these health insurers are also health plan providers for the Medicaid and Medikids programs so there can be a significant overlap in individual providers in some areas of the state. Additionally, Healthy Kids has contracted on a statewide basis with three dental insurers who provide the benefits offered under the comprehensive dental program. Some of the individual dental providers under contract with these insurers also participate in the Medicaid program.

The Children's Medical Services Network also contracts with pediatric specialty and sub-specialty networks to provide services to children enrolled in the CMS program. MediKids mirrors the Medicaid program, offering the same basket of benefits (with the exception of waiver services) and the same provider infrastructure. Depending on their county of residence, MediKids families choose either a Medicaid participating health maintenance organization or a MediPass provider.

2.7 Cost Sharing:

- A. **Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?** NA
- B. **Has your State undertaken any assessment of the effects of cost sharing on utilization of health service under SCHIP? If so, what have you found?** NA

2.8 Assessment and Monitoring of Quality of Care:

- A. **What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.**

The Agency contracts for an annual evaluation that includes measures of quality based on the CHAPS instrument. The Agency also looks at the following:

- Percent of hospitalizations for ambulatory conditions,
- Child deaths,
- Ratio of children seen for mental health services,
- Hospitalization for mental health problems,
- Immunization rates, and
- Well-child visits.

Also, Healthy Kids continues to conduct medical quality audits for each of its contracted health insurers. An initial baseline audit is conducted on any new health plan following the first 12 months of coverage in a county. Thereafter, Healthy Kids has instituted a schedule of re-reviews of these same plans, usually 2-3 years after the initial review. Healthy Kids contracts with an organization, Innovations in Healthcare Quality, to conduct these reviews and provide written reports of the findings. The review examines physician office locations, appointment availability and includes a medical records review. These reviews, once completed, are discussed at publicly noticed meetings of the Board of Directors and are made available to the public upon request. Insurers with deficiencies may be required to submit corrective action plans.

- B. **What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?**

In addition to routinely collecting data on selected measures, the Agency usually contracts with a peer review organization to monitor the quality of care provided to recipients in Medicaid. The Agency credentials providers acting as gatekeepers and monitors the performance of prepaid plans against contract standards that are set in relationship to these criteria.

In addition to the medical quality reviews summarized above, Healthy Kids also requires all health plans and dental insurers to submit quarterly utilization reports. These reports include a listing of all claims paid, procedures conducted and diagnoses codes submitted. Additionally, as part of the family satisfaction surveys conducted by Healthy Kids' evaluators at the Institute for Child Health Policy, families are asked about their perceptions about the quality of care their children receive under the program.

Regarding mental health and substance abuse, there is the Evaluation of the Behavioral Health Specialty Care Network, July 2001, by the Louis de la Parte Florida Mental Health Institute (copy attached), plus on-site monitoring of contractors' performance processes. Such monitoring includes review of contractor adherence to program policies and procedures, working and referral relationships among district contractors, district program offices and district CMSN staff, as well as review of a sample of clinical and/or case management charts to ensure the provision and appropriate recording of services. Central program office staff monitors submission of encounter data.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The Agency plans to continue to fund an annual evaluation of SCHIP. The evaluation is usually available in January of the subsequent year. The Agency also plans to continue to collect data on selected measures for Medicaid. The report on selected measures is generally completed by July of each year.

Also, Healthy Kids will continue to conduct its medical quality audits and collect the quarterly utilization information from its contracted insurers. Medical Quality Audits are available according to a schedule that is set each fiscal year. Additionally, evaluative reports from the Institute for Child Health Policy are submitted to Healthy Kids according to an annual schedule that Healthy Kids and the Institute agree upon each year.

The Behavioral Health Network plans to continue with its program of on-site monitoring and other oversight activities.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

A. Eligibility

There continue to be barriers with eligibility determination for CMS children due to required “medical screening” as a separate component of all other KidCare eligibility determination processes. This is problematic, as over two-thirds of those referred under current screening criteria do not meet the medical eligibility criteria. A new screening instrument was adopted by the National Commission on Quality Assurance (NCQA) to identify children with special needs. This instrument would screen out fewer children who were not eligible for CMS. Adoption of this instrument is being considered.

B. Outreach

The name of the behavioral health program, “Behavioral Health Specialty Care Network”, a long and complex name, made advertising and simple discussion of the program difficult. The name was shortened to the “Behavioral Health Network”. For outreach purposes, the name “BNet” was coined and adopted universally almost immediately. A new logo was designed and all outreach materials redesigned to incorporate the new name and logo. As a result, enrollment has increased and promotion of the program is easier.

Successes:

- A new media message focusing on the value of having and accessing health care;
- Regional KidCare Outreach Projects’ partnerships with providers and advocates;
- Family advocacy process for assisting families with the KidCare program;
- Consolidation of the eligibility process for KidCare and subsidized child care;
- Statewide training related to outreach strategies;
- Data availability to identify underserved populations;
- KidCare Outreach Special Projects targeting underserved populations;
- NE Florida Covering Kids pilot’s collaboration with schools to distribute KidCare applications, train staff and coordinate with free and subsidized lunch programs;
- Palm Beach County new teacher orientation and distribution of KidCare applications to families applying for subsidized child care,

- as well as training of behavioral health professionals and school nurses;
- Palm Beach County inclusion of a health insurance coverage question on its New Student Registration Forms;
- Partnership with the Palm Beach County Sheriff's Office to increase community awareness about the Florida KidCare program;
- Heartlands pilot's collaboration with school districts to distribute KidCare applications to children in the subsidized school lunch program;
- Miami-Dade County pilot's hiring and training of outreach workers from Hispanic and Haitian farm worker communities, as well as from low-income African American communities;
- Florida KidCare Collaboration Projects' coordination of revisions for the Florida KidCare application and brochure, which has simplified and clarified the KidCare application for families; and
- The KidCare partner agencies' development of a pilot project for third parties to pay KidCare premiums on behalf of families in need.

Barriers / (Approaches to Overcome Barriers):

- Language barriers – (outreach workers help families with translations).
- Insufficient choice of providers in certain areas – (Unresolved).
- Need for transportation to clinics – (Unresolved).
- Need for more data feedback to KidCare partners – (Chiles Center and ICHP addressing this)
- Keeping track of families that move to undisclosed locations – (Unresolved).
- Lack of sharing of confidential data between DHACS/Healthy Kids Corporation and the other KidCare partner agencies – (Unresolved).
- Lack of SCHIP funding/coverage for undocumented children – (Unresolved).
- Confusing correspondence sent to families,
- Correspondence which is not provided in the requested language – (Unresolved)
- Healthy Kids Corporation notification to families that parent's social security number is missing, even when not required – (Unresolved).
- Different custodial, guardianship and household income requirements for the different KidCare programs – (Unresolved).
- Recognition of KidCare as one program – (Unresolved).
- Confidentiality issues in identification of Medicaid eligible children – (Unresolved).
- Parents' reluctance to submit a KidCare application because parent's social security number is requested- (Unresolved).
- Duplicate requests to families for immigration documentation – (Unresolved).
- Children under age 5 are not able to buy in to the MediKids program if found to be over income limits for KidCare - (Unresolved).
- Reaching underserved populations, particularly non-citizens who are eligible - (Florida has many children whose families are migrant workers and must move from county to county and state to state. Barriers result from lack of portability of the program and from mistrust of the system and confusion over eligibility of immigrant families. Among strategies to address this barrier are: using local, indigenous outreach workers; and using outreach materials developed by Redlands Christian Migrant Association, such as photo and radio novellas, to address the most prevalent non-citizen eligibility misinformation).
- Sustaining funding for retention-level outreach, once capacity enrollment is achieved – (In process, legislatively).

C. Enrollment

During the 1999-2000 federal fiscal year, the Healthy Kids Corporation completed its statewide expansion and is now available in all 67 Florida counties. Local match was collected for part of the FFY, but was suspended legislatively, and is not currently being collected. A study was completed this year on the effects of county match requirements and is available at the Healthy Kids Corporation website: <http://www.healthykids.org/html/news.html>

BNet enrollment subsequent to September 30, 2000 has increased from 242 to a high of 283 during FFY 2001. Average enrollment for the current period increased from 218 in FFY 2000 to 271 in FFY 2001.

D. Retention/disenrollment

Successes:

As mentioned in previous section, Healthy Kids implemented a participant retention project in November 2000. Phone calls were made to half of the new enrollees each month which welcomed the family to the program, described the payment process, described the benefits available and encouraged the family to seek preventive care for their children.

For families who received a phone call as part of Healthy Kids' enrollment retention pilot project, the amount of time that their children remained enrolled in the program increased and disenrollment due to non-payment of the monthly premium decreased as compared to those enrollees who did not receive a phone call. The success of this limited project led Healthy Kids to decide to expand the project to include phone calls to all new enrollees and to add a supplemental call to the family during the enrollee's birthday month.

Additionally, a recent study conducted by the Institute for Child Health Policy compared the disenrollment and re-enrollment rates for several states. Florida's disenrollment rates remain at a steady percentage through the eligibility period; however, other states experience dramatic decreases in enrollment at re-determination periods.

Florida's lower disenrollment rates can be attributed to the passive redetermination process utilized for Healthy Kids, Medikids and the CMS Network. Rather than requiring families to complete new applications or provide supplemental information, Florida sends the family a listing of the information currently on file and asks that they family contact Healthy Kids by telephone or mail if anything on the account has changed. If nothing has changed, then the coverage is renewed so long as the family continues to make any required premium payment.

E. Benefit structure

During this past federal fiscal year, Healthy Kids released a Request for Proposals for dental insurers for the new dental program. Three insurers were selected through a competitive bid process to provide this benefit to Healthy Kids enrollees on a statewide basis. All three insurers have specific access and appointment standards that must be met in order to ensure that enrollees have adequate access to this new benefit.

F. Cost-sharing

This does not appear to be as much of a barrier as the 60-day wait imposed for non-payment of premium. Less than 5% of disenrollees surveyed reported being dissatisfied with the monthly costs.

G. Delivery system

These appear adequate as few disenrollees report dissatisfaction with providers where the child received most of his care.

H. Coordination with other programs

An excellent vehicle that enhances collaboration among KidCare partners is the KidCare Coordinating Council overseen by the Department of Health. The council meets regularly to discuss issues and develop coordinated approaches to resolving problems. All the partners are working through the Child Health Policy Institute to ensure that data collection is uniform. Considerable effort was placed on ensuring that enrollment is up to date and that the interface between Title XXI and Title XIX programs works efficiently. Some improvements in computer interface are still warranted.

The state continues to struggle with children who move between Title XXI and Title XIX since these two systems don't seamlessly move children between them who continue to be eligible. Please see Section 2.6 for a discussion of our actions in enhancing coordination between programs. FHKC is coordinating a study with a goal of resolving the gaps in coverage.

I. Crowd-out

The Florida KidCare goal regarding this issue is to prevent crowd-out without burdensome policies that could prevent children from obtaining needed services. Most (72%) newly enrolled families whose children had insurance coverage in the 12 months prior to KidCare coverage do not report current access to coverage. Two-thirds of these families report that the employer-based coverage was "too expensive".

J. Other - NA

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).

	Federal Fiscal Year 2001	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments	\$182,208,703		
Managed care	\$107,288,052	\$287,793,228	\$287,793,228
Per member/per month rate X # of eligibles			
Fee for Service			
Total Benefit Costs	\$289,496,755	\$287,793,228	\$287,793,228
(Offsetting beneficiary cost sharing payments)	\$25,220,637	\$22,105,759	\$22,105,759
Net Benefit Costs	\$264,276,118	\$265,687,469	\$265,687,469
Administration Costs			
Personnel	\$843,386	\$397,448	\$397,448
General administration	\$5,240,909	\$2,512,884	\$2,512,884
Contractors/Brokers	\$8,508,321	\$11,112,141	\$11,112,141

(e.g., enrollment contractors)			
Claims Processing	\$706,492		
Outreach/marketing costs	\$ 9,823,667	\$7,441,440	\$ 4,686,200
Other		\$260,000	\$260,000
Total Administration Costs	\$16,147,753	\$16,479,109	\$16,479,109
10% Administrative Cost Ceiling	\$26,427,612	\$26,568,747	\$26,568,747
Federal Share (multiplied by enhanced FMAP rate)	\$195,218,825	\$196,105,772	\$196,105,772
State Share	\$85,205,046	\$86,060,806	\$86,060,806
TOTAL PROGRAM COSTS	\$280,423,871	\$282,166,578	\$282,166,578

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001. NA

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

- State appropriations
- County/local funds (For part of the year, see A. below).
- Employer contributions
- Foundation grants
- Private donations (such as United Way, sponsorship)
- Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures?

The 2000 Florida Legislature directed FHKC to study the local match issue and to present a multi-year plan for the reduction in local match levels. The Healthy Kids Corporation collects over \$11 million currently in local matching funds. The Florida Legislature froze these commitments at the 1999-2000 commitment levels while the Corporation conducted its study. Previously, counties contributed local match based on the number of children the county wished to enroll above its base allocation of enrollment availability. Each county received a base number of slots that did not require any matching funds. For enrollment above this allocation, counties contributed based on a five-year local match rate schedule. The match rates ranged from 5% to 20% of the costs of the health care coverage. These funds provide some of the non-federal share of Florida's Healthy Kids Title XXI expenditures.

The final report that was sent to the governor and Legislature recommended that the local match shares be reduced over a three-year period. Under this proposal, no county would pay more than 10% of the county's health care costs for its enrollees above a base allocation by year three. Counties would receive their allocation based on the number of children under the age of 19 in the county. Match would be applied for additional counties according to one of three schedules. The three schedules would be based on the county's economic base or some other indicator of county revenue. If the Legislature adopts this recommendation, it may result in reduced funds from the counties and the replacement of these lost funds with additional state revenues. A copy of the report is attached.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table5.1	Medicaid Expansion SCHIP program	Separate SCHIP program	Separate SCHIP program	Separate SCHIP program
Program Name	Medicaid	Healthy Kids	MediKids	CMS
Provides presumptive eligibility for children	<input checked="" type="checkbox"/> No Yes, for whom & how long?	<input checked="" type="checkbox"/> No Yes, for whom & how long?	<input checked="" type="checkbox"/> No Yes, for whom & how long?	<input checked="" type="checkbox"/> No Yes, for whom & how long?
Provides retroactive eligibility	No <input checked="" type="checkbox"/> Yes, for whom & how long? All Medicaid eligibles, for 3 months	<input checked="" type="checkbox"/> No Yes, for whom & how long?	<input checked="" type="checkbox"/> No Yes, for whom & how long?	<input checked="" type="checkbox"/> No Yes, for whom & how long?
Makes eligibility determination	<input checked="" type="checkbox"/> State Medicaid eligibility staff Contractor Community-based organizations Insurance agents MCO staff Other (<i>specify</i>)	State Medicaid eligibility staff <input checked="" type="checkbox"/> Contractor Community-based organizations Insurance agents MCO staff Other (<i>specify</i>)	State Medicaid eligibility staff <input checked="" type="checkbox"/> Contractor Community-based organizations Insurance agents MCO staff Other (<i>specify</i>)	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input checked="" type="checkbox"/> Contractor Community-based organizations Insurance agents MCO staff Other (<i>specify</i>)
Average length of stay on program	Specify months – <1: 6.8 15-19: 6.06	Specify months -	Specify months -	Specify months –
Has joint application for Medicaid and SCHIP	No <input checked="" type="checkbox"/> Yes	No <input checked="" type="checkbox"/> Yes	No <input checked="" type="checkbox"/> Yes	No <input checked="" type="checkbox"/> Yes

Table5.1	Medicaid Expansion SCHIP program	Separate SCHIP program	Separate SCHIP program	Separate SCHIP program
Program Name	Medicaid	Healthy Kids	MediKids	CMS
Has a mail-in application	No <input checked="" type="checkbox"/> Yes	No <input checked="" type="checkbox"/> Yes	No <input checked="" type="checkbox"/> Yes	No <input checked="" type="checkbox"/> Yes
Can apply for program over phone	<input checked="" type="checkbox"/> No Yes	<input checked="" type="checkbox"/> No Yes	<input checked="" type="checkbox"/> No Yes	No <input checked="" type="checkbox"/> Yes
Can apply for program over internet	No X Yes, FHKC pilot program with assisted application process utilizing trained volunteers in selected pilot sites, and accessing a password protected secure web page.	No X Yes, FHKC pilot program with assisted application process utilizing trained volunteers in selected pilot sites, and accessing a password protected secure web page.	No X Yes, FHKC pilot program with assisted application process utilizing trained volunteers in selected pilot sites, and accessing a password protected secure web page.	No X Yes, FHKC pilot program with assisted application process utilizing trained volunteers in selected pilot sites, and accessing a password protected secure web page.
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No Yes	<input checked="" type="checkbox"/> No Yes	<input checked="" type="checkbox"/> No Yes	<input checked="" type="checkbox"/> No Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input checked="" type="checkbox"/> No Yes, specify # of months What exemptions do you provide? N/A	No <input checked="" type="checkbox"/> Yes, specify # of months - Must be uninsured at time of application. What exemptions do you provide? KidCare will enroll a child who is underinsured (i.e. school accident insurance).	No <input checked="" type="checkbox"/> Yes, specify # of months - Must be uninsured at time of application. What exemptions do you provide? KidCare will enroll a child who is underinsured (i.e. school accident insurance).	No <input checked="" type="checkbox"/> Yes, specify # of months - Must be uninsured at time of application. What exemptions do you provide? KidCare will enroll a child who is underinsured (i.e. school accident insurance).
Provides period of continuous coverage regardless of income changes - Coverage is six months from the last determination of eligibility for children 5 to 19, and 12 months for those under age 5. Coverage can be lost by moving out of state or if the child dies.	No <input checked="" type="checkbox"/> Yes, specify # of months Explain circumstances when a child would lose eligibility during the time period (*please see below)	No <input checked="" type="checkbox"/> Yes, specify # of months - 6 Explain circumstances when a child would lose eligibility during the time period - <i>Eligibility can be lost due to a missed monthly premium payment, enrollment in Medicaid, change in parents' employment status (ie: parent becomes a state employee with benefits).</i>	No <input checked="" type="checkbox"/> Yes, specify # of months - 6 Explain circumstances when a child would lose eligibility during the time period - <i>Eligibility can be lost due to a missed monthly premium payment, enrollment in Medicaid, change in parents' employment status (ie: parent becomes a state employee with benefits).</i>	No <input checked="" type="checkbox"/> Yes, specify # of months - 12 Explain circumstances when a child would lose eligibility during the time period - <i>Eligibility can be lost due to a missed monthly premium payment and/or annual medical eligibility redetermination resulting in a child being no longer medically eligible for CMS,</i>

Table5.1	Medicaid Expansion SCHIP program	Separate SCHIP program	Separate SCHIP program	Separate SCHIP program
Program Name	Medicaid	Healthy Kids	MediKids	CMS
				<i>enrollment in Medicaid, change in parents' employment status (ie: parent becomes a state employee with benefits).</i>
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No Yes, how much? Who Can Pay? Employer Family Absent parent Private donations or sponsorship Other (specify)	No <input checked="" type="checkbox"/> Yes, how much? \$15 per family, per month. Who Can Pay? Employer <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/> Absent parent Private donations or sponsorship Other (specify)	No <input checked="" type="checkbox"/> Yes, how much? \$15 per family, per month Who Can Pay? Employer <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/> Absent parent - Private donations or sponsorship Other (specify)	No <input checked="" type="checkbox"/> Yes, how much? \$15 per family, per month Who Can Pay? Employer <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/> Absent parent Private donations/sponsors hip Other (specify)
Imposes co-payments or coinsurance	<input checked="" type="checkbox"/> No Yes	No <input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No Yes	<input checked="" type="checkbox"/> No Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No Yes	No <input checked="" type="checkbox"/> Yes, we send out form to family with their information and: <ul style="list-style-type: none"> ❖ ask for a signed confirmation that information is still correct ❖ do not request response unless income or other circumstances have changed 	No <input checked="" type="checkbox"/> Yes, we send out form to family with their information and: <ul style="list-style-type: none"> ❖ ask for a signed confirmation that information is still correct ❖ do not request response unless income or other circumstances have changed 	<input checked="" type="checkbox"/> No Yes, we send out form to family with their information and: <ul style="list-style-type: none"> ❖ ask for a signed confirmation that information is still correct ❖ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

For Healthy Kids, MediKids, and CMS, the redetermination process differs from the initial application process in that the family is not required to complete another application. The family receives a letter indicating all of the information listed on the account and is asked to contact the Healthy Kids Corporation only if any of the information has changed. If the family has no changes, it simply continues to make monthly premium payments and remains on the program. If the family has changes, it may call the Healthy Kids Corporation and report these changes. If the information indicates that the family may now be eligible for Medicaid, an electronic referral is made to DCF.

For the Medicaid program there is no difference. The single KidCare application form is used at application and re-determination.

SECTION 6: INCOME ELIGIBILITY

- 6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?** If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

**Title XIX Child Poverty-related Groups or
Section 1931-whichever category is higher**

185% of FPL for children under age 1
133% of FPL for children aged 1 to 6
100% of FPL for children aged 6 to 18

Medicaid SCHIP Expansion

200% of FPL for children aged under 1
100% of FPL for children aged 15 to 19 *
 % of FPL for children aged

Separate SCHIP Program

200% of FPL for children aged 1 to 19
 % of FPL for children aged
 % of FPL for children aged

* As of 9/30/01, the period this report covers, the only children left in this group are those 17 to 19 year-olds. The rest have "aged" into Title XIX as they were born prior to 10/1/83.

- 6.2 As of September 30, 2001, what types and amounts of disregards and deductions does each program use to arrive at total countable income?** Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

Yes No

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	\$90+\$110+1/2	\$ SAME	\$ 0
Self-employment expenses	\$Allowable costs of and disregards	\$ SAME	\$ 0
Alimony payments Received	\$ No disregard	\$ SAME	\$ 0
Paid	\$ Court-ordered amount	\$ SAME	\$ 0
Child support payments Received	\$50	\$ SAME	\$ 0
Paid	\$ Court-ordered amount	\$ SAME	\$ 0
Child care expenses	\$200 per month for children <2; \$175 for children 2 and older	\$ SAME	\$ 0
Medical care expenses	\$ No disregard	\$ SAME	\$ 0
Gifts	\$30 per quarter	\$ SAME	\$ 0
Other types of disregards/deductions (specify)	\$ * (Please see below)	\$ NONE	\$ 0

*For the non-Medicaid portions of SCHIP (Title XXI), no income or earnings disregards are considered.

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

No Yes, specify countable or allowable level of asset test _____

Medicaid SCHIP Expansion program

No Yes, specify countable or allowable level of asset test _____

Separate SCHIP program

No Yes, specify countable or allowable level of asset test _____

Other SCHIP program NA

No Yes, specify countable or allowable level of asset test _____

6.4 Have any of the eligibility rules changed since September 30, 2001?

Yes No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

As discussed in Section 4.3, local match remains an issue that will be addressed by the 2002 Florida Legislature.

- A. Family coverage - NA
- B. Employer sponsored insurance buy-in - NA
- C. 1115 waiver - NA
- D. Eligibility including presumptive and continuous eligibility - NA
- E. Outreach - NA

The outreach materials for the Behavioral Health Network are unique to that program. The outreach materials have only been available in English to date. Spanish and Haitian Creole translations of the materials have been completed and materials in those languages are available.

Special Project one-year contracts were developed in order to target and reach underserved populations. The Special Projects target faith-based communities, schools, community centers, businesses and other organizations with underserved populations.

Media materials were developed to target the American Indian/Alaskan Native population and the rural Hispanic population.

The Department of Health will also continue its efforts to “institutionalize” KidCare outreach by continuing to pursue consolidation of the KidCare eligibility process with other government-funded programs. Following the principles outlined in the Kaiser Commission Report “Express Lane Eligibility,” KidCare joint eligibility with WIC, health departments, and free and reduced lunch programs will be pursued.

The Department of Health will shift its outreach focus to retention of KidCare enrollees, by concentrating on training community partners, educating families on the value of having and using health insurance services, and maintaining KidCare name recognition in communities so that KidCare enrollment is maintained and children’s access to health care is improved, thereby encouraging preventative care and

reducing unnecessary emergency room visits and costs.

The KidCare partner agencies currently are engaged in a process to explore the feasibility of merging several call centers or creating a single call center for all KidCare-related calls. The KidCare partner agencies will continue to pilot a process for allowing third parties to pay premiums on behalf of families in need.

The KidCare Coordinating Council, a legislatively established group to provide recommendations to the Governor and Legislature on improving the KidCare program, provided its annual recommendations for FY 2001-2002. The 2001 Florida Legislature adopted proviso language in the General Appropriations Act which addressed two Council recommendations: (1) replacing the Healthy Kids local match requirement, and (2) establishing a voluntary local matching opportunity to enhance outreach funding opportunities. In addition, members of Florida's Congressional Delegation sponsored a bill that addresses another Council priority: allowing Title XXI funds to be used to provide health benefits coverage to legal immigrant children.

The Healthy Kids Corporation spearheaded a KidCare Coordinating Council recommendation by implementing a KidCare on-line application pilot project. The Florida KidCare Resource Marketing Guide was revised and condensed to be user-friendly for the KidCare Outreach Coordinators and their staff. The guide includes an introduction to basic marketing theory, step-by-step "how-to" guidelines for marketing with print, radio, TV and the press. In addition, it gives specific guidelines for using KidCare marketing materials, examples of outreach strategies, print ads, press releases, and other materials that will enhance local outreach efforts and a style guide for using the KidCare logo and artwork.

The Robert Wood Johnson's Peer Match Innovations Program matched KidCare Coordinators who had an issue or barrier regarding outreach with one of their peers who had successfully addressed the same issue. The issues or barriers addressed during the past year included data management; school board administration issues related to free and reduced lunch, homeless children, improving community collaboration and account management for effective utilization of resources. The peer match program has been received with much enthusiasm.

Robert Wood Johnson has developed two reports describing their innovative outreach techniques to reach underserved vulnerable populations. One describes how firefighters, fire rescue workers and sheriff's deputies reached out to families to motivate them to ensure their children. The second report is about how another Robert Wood Johnson pilot used a Teddy Bear clinic to encourage families to enroll their children in KidCare.

The Department of Health is collaborating with other state agencies and key child advocates to develop a child health strategic plan. The purpose of the plan will be to coordinate and strengthen the health care system for children with particular attention to assuring primary care through medical homes, and coordination of public health services that keep children enrolled and utilizing KidCare. The Department will meet with key staff and stakeholders, write the strategic planning document, and develop briefing sheets and a child health booklet covering specific issues such as access to care, key indicator data, and developmental issues.

Enrollment/redetermination process - NA

Contracting - NA

Other - NA