Florida KidCare Eligibility Determination Study
Report to FHKC Board of Directors

Since the adoption of the Florida KidCare Act in 1998, the partner agencies responsible for administering the programs have made significant progress in how applications are received and screened, eligibility is determined, and children are enrolled in health plans or provider networks. Consumer surveys show that these efforts have had desirable results, with general program satisfaction remaining at a consistently high level. For example, the latest Annual KidCare Evaluation reports that over 95% of applicant families are satisfied with the mail-in application process.

This successful record over the past four years makes each of the KidCare partners well-qualified to participate in a collaborative, team-oriented effort to analyze the eligibility determination processes and identify opportunities to create an even better consumer experience.

In a demonstration of its commitment to ongoing quality improvement, early this year the Florida Healthy Kids Corporation asked MAXIMUS, Inc., to study the KidCare eligibility determination processes to identify further opportunities for improved customer satisfaction by focusing on three general goals:

- *Reduce the time it takes to process an application and enroll an eligible child ("Timeliness").*
- *Facilitate enrollment in the right program ("Program Fit").*
- *Reduce the chances of a break in coverage for a child who is moving from Medicaid to a non-Medicaid Title XXI program ("Gap in Coverage").*

In addition, the MAXIMUS team was asked to limit the scope of its Phase I work to changes that could be considered within the boundaries of existing state and federal law. In developing its recommendations, the MAXIMUS team relied on a process that emphasized collaboration, feedback, mutual respect, and a realistic sense of what was possible given programmatic and budgetary constraints.

MAXIMUS presented 28 recommendations to the Florida Healthy Kids Corporation Board of Directors on April 12, 2002. A similar presentation was made to the KidCare Coordinating Council a week later. Subsequent to these meetings, FHKC engaged MAXIMUS for Phase II to identify the tasks that would be required to implement each recommendation and to estimate the costs and benefits for each change.

Over five days of meetings in Tallahassee and four additional conference calls, each KidCare partner provided information critical to this cost/benefit analysis and helped clarify the scope of work associated with each recommendation. Without the cooperative tone and educated approach used by each partner's representatives, the Phase II cost/benefit analysis would have been unreliable at best, futile at worst. A complete listing of the people who contributed to these productive discussions is attached.

The Phase II work will culminate in a presentation to the FHKC Board of Directors on June 5, 2002. This presentation will summarize the cost/benefit work facilitated by MAXIMUS, as well as the response of the special subcommittee appointed by the Board to suggest a potential course of action after a review of the costs and benefits of each recommendation.

The special subcommittee (The Eligibility Improvement Subcommittee) is composed of the following members:

- Dr. Louis St. Petery, Chair
- John Benz, South Broward Hospital District
- Bob Cohen, DCF (represented at the 5/20 meeting by Linda Dilworth)
- Dr. Steve Freedman
- Bob Sharpe, AHCA (represented at the 5/20 meeting by Mary Pat Moore)
- Phyllis Sloyer, DOH

This document outlines the costs, benefits, and implementation challenges associated with each recommendation. In the original MAXIMUS report, the recommendations were grouped by probable implementation timeframe, starting with those that could be carried out immediately. This organization by timeframe is how the recommendations received their original numbers. In this document, they are grouped by the three principal consumer goals. The level of effort is described using the three following categories:

- "Easy" means a recommendation can be fully implemented with existing resources and a nominal amount of coordination among the involved entities
- "Moderate" means a recommendation that can be implemented with a reasonable amount of coordination and existing resources, although a reordering of existing work priorities may be needed over a relatively short period of time
- "Challenging" means a recommendation that will require considerable coordination and a definite reordering of existing priorities or the deployment of additional resources

The action of the special subcommittee is reflected in this report according to three categories:

- "Recommends Approval" means the special subcommittee reached consensus that the recommendation should be implemented
- "Recommends Further Study" means the special subcommittee believes the recommendation requires additional study and discussion among the affected KidCare partners before agreement can be reached on whether to proceed
- "Significant Support; Major Planning Required" means the special subcommittee concurred with the objectives of the recommendation but recognized that significant planning or implementation hurdles remain
- "Recommends Set Aside" means the special subcommittee believes the recommendation is not feasible or will not generate demonstrable consumer-oriented improvements

In addition, the special subcommittee agreed to recommend to the FHKC Board that Randy Fritz, the principal MAXIMUS consultant, be retained for a Phase III to assist with implementation of the recommendations that are approved and facilitate discussion of the items that are identified as needing further study.

Cost and benefit estimates were calculated using data from calendar year 2001. The information described above is also briefly summarized in a separate "quick reference" table. Unless otherwise noted, each recommendation requires the involvement of AHCA, DCF, FHKC, and DHACS (the third party administrator under contract to FHKC).

RECOMMENDATIONS TARGETED TO TIMELINESS

This goal is directly related to the amount of time it takes for an eligible child's coverage to begin. While the timeliness of the application process has demonstrably improved over the past several years, there are additional opportunities for even better performance.

Recommendation #1: Change the Medicaid Screen to Count Social Security Income.

BENEFIT:	**Up to 3.9% of all children avoid unnecessary DCF referral, 4,414 DCF production hours saved**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, one month**
COST:	**$800 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

The automated algorithm DHACS uses to identify children potentially eligible for Medicaid should be changed to count, rather than disregard, Social Security income. This change should significantly reduce the number of "false positive" referrals to the Department of Children and Families (DCF), lessening the time it takes to process those applications and eliminating unnecessary work at DCF. Implementation tasks include:

- Modify Title XXI state plan amendment
- DCF will need to draft a revised administrative memo concurring with the change in the Medicaid eligibility screen
- Reprogram the DHACS automated system ("CHAS")

Benefits: 38,925 children were referred to DCF in 2001 and were subsequently denied Medicaid eligibility (22% of all DCF referrals). Of these children, 15,870 (or 40.8%) were from families reporting social security income. It is reasonable to assume that most of these referrals would not have occurred if social security income had been counted. DCF estimates 4,414 production hours will be saved.

Recommendation #2: Do Not Make the State Employee Match a Pre-Condition of Eligibility.

BENEFIT:	**Up to 26.2% of all eligible children begin coverage one month sooner (except families who do not make a timely payment)**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, one month**
COST:	**$3,100 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

The monthly data matching process that is used to identify children who are the dependents of state employees (and are therefore ineligible for the Title XXI subsidy) should treat KidCare applicants as presumptively not state employees, with the monthly match only a program integrity strategy to identify those who are or become state employees. Implementation tasks include:

- Reprogram CHAS
- AHCA confirms with the Centers for Medicare and Medicaid Services that this approach does not conflict with federal guidelines

Benefits: This change will reduce the time it takes to process a completed application, leading in many cases to coverage beginning a month earlier. 62,375 families had applications that were entered into CHAS no more than 14 days after the data match and which were submitted without critical missing data (26.2% of applicant families).

Recommendation #7: Mitigate the Impact of the Medicaid Match Strategy through a Daily or Weekly Incremental Match.

BENEFIT:	**Up to 26.2% of all eligible children begin coverage one month sooner (except families who do not make a timely payment) and 5.9% of children avoid unnecessary referrals to DCF**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, 6-12 months**
COST:	**$8,300 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

The eligibility determination process should be changed to identify applicant children who are currently enrolled in Medicaid on a more expeditious basis. The monthly match will continue to be needed to identify children who are simultaneously enrolled in Medicaid and a non-Medicaid Title XXI program. CHAS will need to be changed so that the monthly match is not a pre-requisite to an eligibility determination and incremental files are produced on a schedule that is yet to be determined (at least weekly). The interface with FMMIS will replicate the current monthly process.

Benefits: Like #2, this change will reduce the time it takes to process a completed application, leading in many cases to coverage beginning a month earlier. It will also significantly reduce the likelihood that a child currently on Medicaid will be referred to DCF. 24,295 children referred to DCF in 2001 were already on Medicaid (13.7% of all referrals).

Recommendation #5a: Electronically Transmit the MediKids Provider Choice File More Frequently.

BENEFIT:	**More timely generation of premium notices**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, one month**
COST:	**Nominal**
SUBCOMMITTEE ACTION:	**Recommends Approval**

Under the current environment, MediKids provider choices are sent to DHACS only two or three times a month. This recommendation does not involve DCF. Changing the provider choice file schedule will involve minimal changes to the business processes at ACS and DHACS.

Benefits: Implementation of this recommendation will facilitate more timely generation of premium payment notices in some cases. It is not possible to estimate the number of families that would be affected.

Recommendation #5b: Permit New Enrollees to be Added to the Supplemental File.

BENEFIT:	**At least 17% of children eligible for MediKids (or 1% of all applicant children) will start coverage one month sooner and avoid having a different coverage period from an older sibling**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, 6-12 months**
COST:	**$1,400 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

Under the current environment, children who are found to be eligible for MediKids in the latter half of the month must wait an additional month for coverage because MediKids does not accept new enrollees via the supplemental file. This recommendation does not involve DCF. The DHACS and ACS systems will require re-programming.

Benefits: Adding new enrollees to the supplemental file will enable some children to begin coverage in MediKids a month earlier. 3,930 MediKids children had older siblings that began coverage in Healthy Kids or CMSN a month earlier.

Recommendation #25: Synchronize the Monthly Processing Schedules for MediKids and Healthy Kids/CMSN.

BENEFIT:	**17% of children eligible for MediKids (or 1% of all applicant children) avoid having a different coverage period from an older sibling**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, 2-3 months**
COST:	**$16,600 (one-time cost)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

Different cut-off dates for MediKids and Healthy Kids/CMSN means that, under certain circumstances, a younger child eligible for MediKids will have to wait an additional month for coverage to start compared to siblings who qualify for Healthy Kids and/or CMSN. This recommendation does not involve DCF.

If AHCA, DHACS, and FHKC can agree on a process for avoiding data anomalies that currently prompt manual intervention at AHCA, the delivery date of the MediKids file could be moved at least 4 or 5 calendar days closer to the Healthy Kids/CMSN schedule. Similarly, the Healthy Kids/CMSN schedule can be moved earlier in the month if adjustments are made to the production of the monthly supplemental file. The assumptions that underlie these tasks will also be affected by the decision regarding Recommendation 5b (pertaining to the MediKids supplemental file).

Recommendation #6: Electronically Transmit All Available Sibling Information to DCF.

BENEFIT:	**10.7% of applications processed sooner, 5,294 DCF production hours saved**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, 2-3 months**
COST:	**$3,720 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

All available sibling information should be included in the referral file so that DCF staff can more accurately determine the number of family-members living within the household. Implementation tasks include:

- Reprogram CHAS and KISS (the DCF KidCare intermediary system)
- Change DCF processing protocols so the additional sibling information is used by DCF Public Assistance Specialists

Benefits: Giving DCF additional information to help determine family size will speed the processing of any application that includes siblings who are included on the application but are not currently included in the referral file. In 2001, there were 25,411 families with at

least one child referred to DCF and at least one child not referred to DCF (10.7% of all applicant families). DCF estimates 5,294 production hours will be saved.

Recommendation #9: Solicit Missing Information by Phone.

BENEFIT:	**Up to 21.8% of applications processed 7-10 days sooner**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, 1-2 months**
COST:	**$800 (one-time) and $8,000 in annual phone charges**
SUBCOMMITTEE ACTION:	**Recommends Approval**

Around one-third of all applications arrive at DHACS lacking information that is needed to determine a child's eligibility for Medicaid or Title XXI. In addition to a missing information letter, the FHKC auto-dialer should be used to solicit the information by phone. This recommendation does not involve DCF or AHCA. The primary task is creating a file exchange protocol between CHAS and the auto-dialer.

Benefits: When a family is successfully reached by phone and responds to the request to call the hotline, the application will finish processing sooner. 52,016 families submitted applications that were missing only those items that can be collected over the phone (21.8% of all applications). For these families, responding to an auto-dialer phone call rather than a missing information letter will save 7-10 days.

Recommendation #13a: Application Changes Involving Data Elements and System Impacts.

BENEFIT:	**10.9% of applications processed sooner, compliance with Office for Civil Rights (OCR) directives**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, six months**
COST:	**$10,400 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

- **Information for Non-Applicant Children.** The current application does not adequately account for the differences in how Medicaid and Title XXI calculate family size. *(Office for Civil Rights required change.)*
- **Multiple health status questions to replace the single child-level question.** (see Recommendation #10)
- **Questions to align the application fully with the Medicaid eligibility criteria.** (see Recommendation #22)
- **Race/Ethnicity.** Add an "Optional" question for race/ethnicity and provide race/ethnicity codes or abbreviations from which applicants may choose. *(Office for Civil Rights recommended change.)*

Implementation tasks include:

- Application Workgroup reaches consensus on all changes to the application (individual changes cannot be considered in a vacuum)
- Reprogram CHAS and KISS
- Change DCF processing protocols so the additional sibling information is used by DCF Public Assistance Specialists

Benefits: Collecting non-applicant child information at the time of the original application will speed the processing of certain Medicaid referrals and reduce the workload at DCF. In 2001, there were 26,064 KidCare applications referred to DCF with a mismatch between household size and the number of children and parents/guardians as listed on the first page. This was 10.9% of all applications and 21.1% of DCF referrals.

Recommendation #13b: Application Changes Involving Information-Only Elements.

BENEFIT:	**8.9% of applications processed up to 25 days sooner, compliance with Office for Civil Rights (OCR) directives**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, six months**
SAVINGS:	**Up to $16,000 in annual savings (because immigration documentation "missing info" letter is averted)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

- **Request immigration documentation** (currently, only some Spanish and Creole applications do this)**.**
- **Parent SSN clarification.** The word "Optional" should be parenthetically placed underneath or next to the space where the parent's SSN is written. A statement is also needed in the brochure describing how a parent's SSN will be used and confirming that the application will not be denied if the SSN is not provided. *(Office for Civil Rights required change.)*
- **Public charge.** Information about the public charge issue in the brochure to allay fears that submission of a KidCare application may put at risk any immigrant family's plans to seek U.S. citizenship, including the fact that SSNs will not be shared with the INS. *(Office for Civil Rights required change.)*
- **Parent's DOB.** Parents' date-of-birth should only be retained if it is used to screen for potentially eligible teen parents.
- **Context for health status questions(s) and day care question.**
- **A brief reminder of the difference between "Social Security" income and "SSI" income.**

If Recommendation #12 is adopted (requiring child's SSN), the workgroup should consider whether any text should be added to the application or brochure noting that this information must be provided. This recommendation also requires the involvement of DOH.

Benefits: Collecting immigration documentation at the time of the original application will expedite the processing of any application that involves non-citizen applicant children and that is otherwise complete. 21,234 applications in 2001 generated a missing information letter for immigration documentation and did not lack any other critical information (8.9% of all applications). For these families, an average of around 25 days will be saved if the documentation is submitted with the application.

Recommendation #14: DHACS Review of Immigration Documentation Should Be Accepted for Medicaid Review Purposes.

BENEFIT:	**2.7% of applications avoid duplication of effort at DCF**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, concurrent with #13b**
COST:	**Nominal**
SUBCOMMITTEE ACTION:	**Recommends Further Study**

If DHACS reviews the immigration documentation of non-citizen children prior to their referral to DCF (see Recommendation #13b), then a subsequent review at DCF will be unnecessary. Implementation tasks include:

- Change DCF policy so that Public Assistance Specialists do not screen for immigration documentation when that work has already occurred at DHACS
- Audit strategy for quality assurance and program accountability purposes
- DCF may need to consider the need for look-ups into SAVE when immigration documentation has been received and screened

Benefits: Implementation of this recommendation will avoid duplication of effort at DCF. In 2001, there were 6,404 KidCare applications referred to DCF with at least one child requiring immigration documentation (5.2% of all apps referred to DCF).

Recommendation #15: Implement a Statewide Online KidCare Application.

BENEFIT:	**Approximately 50% greater likelihood of an application being submitted fully complete and a faster time to an eligibility finding (assuming online submission of data)**
LEVEL OF EFFORT/ TIMEFRAME:	**Challenging, 6-8 months**
COST:	**Range between $51,800 and $600,000 (to develop and deploy the site)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

An online KidCare application should be deployed statewide to permit electronic entry of application information, generation of a tentative eligibility determination, and submission of electronic data or production of a written application at the family's printer. Evaluation of the FHKC micro-pilot will help determine the best way to design and deploy a statewide online application accessible to all interested families. The involvement of DOH is also needed. Implementation tasks include:

- KidCare partners agree whether the site will accept electronic submittal of data or only generate a written application at a family's printer
- FHKC selects contractor to develop and maintain the website
- If data will be submitted electronically, CHAS must accept the data and also ensure appropriate Internet security to prevent unauthorized access to CHAS
- Extraction of the DHACS eligibility algorithm for incorporation into the website design to facilitate tentative "real-time" determinations

Recommendation #20: Process KidCare Applications in Florida.

BENEFIT:	**Savings of one processing day**
LEVEL OF EFFORT/ TIMEFRAME:	**Challenging, concurrent with relocation of other DHACS functions to Florida**
COST:	**$200,000 (one-time) and $225,000 annual costs (net of current operating costs)**
SUBCOMMITTEE ACTION:	**Recommends Further Study**

If DHACS locates an operation in Florida, perhaps for a call center or some other significant operational component, the scope of that operation could be expanded to include the opening, batching and scanning of applications. This recommendation does not involve AHCA or DCF. It would be a significant operational change with numerous implementation tasks, both large and small.

RECOMMENDATIONS TARGETED TO PROGRAM FIT

This goal has to do with both program integrity (accurately evaluating a family's situation in light of the various eligibility criteria among the KidCare programs) and ensuring that the differing eligibility determination processes across the programs do not confuse or intimidate applicants.

Recommendation #4: Maintain the Title XXI Continuous Eligibility Period for Families that Self-Report Changes in Income or Household Size to DHACS.

BENEFIT:	**Enhanced continuity of care**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, 4-6 months**
COST:	**Not available at this time**

SUBCOMMITTEE ACTION: Recommends Further Study

The recommendation seeks to resolve an apparent conflict between the Florida KidCare Act, which stipulates six months of continuous eligibility for all children enrolled in a Title XXI program, and KidCare program policy, in which families are referred to DCF anytime they report a change in income or family size. Implementation tasks include:

- AHCA, DCF and FHKC agree on a cost-sharing policy for Title XXI families that report a change that will prompt a referral to DCF during the regular renewal period
- AHCA, DCF and FHKC agree on the time parameters of the renewal period
- Reprogram CHAS to prevent a referral outside of the renewal period

Benefits: Maintaining six months of continuous eligibility for families that experience a downward change in income will promote continuity of care. The number of children or families who will be affected by this change cannot be reliably identified.

Recommendation #3: Add Health Status and Immigration Information to the Passive Renewal Notice.

BENEFIT:	**Enhanced opportunity for families to report relevant changes in a child's citizenship and/or health status**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, one month**
COST:	**$4,100 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

Just as the KidCare application gives families the chance to identify children with special health care needs, we believe the passive renewal process should do that as well. The renewal form should also be modified to solicit updated immigration documentation from families with a non-qualified non-citizen child. This recommendation does not involve DCF or AHCA but does involve DOH. Implementation tasks include:

- Redesign of the renewal notice templates and CHAS reprogramming
- Training of hotline operators to deal with the CMSN screening questions
- Reprogramming of CHAS
- Modification of the renewal form data entry business rules

Benefits: Providing an additional and recurring means of ensuring that children with special health care needs are identified will be beneficial since CMSN is specifically designed to meet the unique needs of those children. Requesting updated documentation from certain immigrant families will ensure that children who are newly eligible for Medicaid or the Title XXI subsidy will not be denied or placed on waiting lists.

Recommendation #10: Re-engineer the CMSN medical eligibility determination process.

BENEFIT:	**Up to 4.6% of applicant children avoid an unnecessary CMSN referral and 20,000 DOH production hours saved**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, 4-6 months**
COST:	**$19,800 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

The KidCare application's child-specific health status question should be eliminated in favor of a multi-question test to initially screen children for CMSN status at a much more detailed and uniform level. The involvement of DOH is also needed. Implementation tasks include:

- Application Workgroup reaches consensus on all changes to the application (individual changes cannot be considered in a vacuum)
- Reprogram CHAS and the CMSN system
- Modify the CMSN medical eligibility determination business processes

Benefit Factor(s): Adopting a more reliable and efficient means of screening children for CMSN medical eligibility will reduce the number of "false positive" referrals and improve the program's ability to make correct determinations on a faster basis. In 2001, there were 18,923 "false positive" CMSN medical eligibility referrals, or 83.6% of all CMSN referrals.

Recommendation #11: Improve the Automated Link between CMSN and DHACS.

BENEFIT:	**2.2% of children more likely to enroll in appropriate health plan**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, 2-3 months**
COST:	**$4,700 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

Modify the interface between CHAS and the CMSN system to improve the chances that a child who qualifies for Medicaid and CMSN will not mistakenly enroll in MediPass or a Medicaid HMO. DCF and AHCA do not need to be involved but DOH does. The primary implementation task is modifying the interface between CHAS and the CMSN system.

Benefits: This system change will improve the chances that a child who qualifies for Medicaid and CMSN will not mistakenly enroll in MediPass or a Medicaid HMO. Of the 22,642 medical eligibility referrals to CMSN in 2001, 9,007 (39.8%) involved children who were also determined by DCF to be eligible for Medicaid.

Recommendation #26a: Align the CMSN Medical Eligibility Determination Process for Medicaid Children.

BENEFIT:	**Approximately 8,000 children more likely to enroll in appropriate health plan**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, 1-2 months**
COST:	**Nominal**
SUBCOMMITTEE ACTION:	**Recommends Approval**

Align all CMSN medical eligibility determination processes, including the Medicaid health provider choice process. This recommendation does not involve DCF but it does involve DOH. The principal tasks are revising the Medicaid enrollment broker material and hotline business processes to align with the changes proposed in Recommendation #10 and considering whether to create a CMSN auto-assignment process with a family "opt out" option.

Recommendation #26b: Develop an Interface between Medicaid Enrollment Broker and CMSN.

BENEFIT:	**Approximately 8,000 children more likely to enroll in appropriate health plan**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, 2-3 months**
COST:	**$1,800 (one-time cost), costs associated with possible Concera interface TBD**
SUBCOMMITTEE ACTION:	**Recommends Further Study**

Concera should collaborate with CMSN and AHCA to develop an interface to transmit responses to the multi-question test proposed in Recommendation #10.

RECOMMENDATIONS TARGETED TO PREVENTING A GAP IN COVERAGE

Under the current processes, it is very likely that a child moving off of Medicaid as the result of a periodic re-determination will lose coverage for one or two months. One of the most common themes in the interviews with all KidCare partners and stakeholders was the need for a more reliable and timely strategy. These recommendations address that need.

Recommendation #8: Implement an Automated Referral Process for Children Leaving Medicaid.

BENEFIT:	**Around 28,000 children per year less likely to experience gap in coverage, 803 DCF production hours saved**
LEVEL OF EFFORT/ TIMEFRAME:	**Moderate, 6-8 months**

COST:	**$18,700 (one-time), $24,000 annual correspondence costs**
SUBCOMMITTEE ACTION:	**Recommends Approval**

To replace the manual process centered around the 2092 form, an electronic file exchange between DCF and DHACS should be deployed to facilitate the transition of children leaving Medicaid to enroll in Healthy Kids, MediKids, or Title XXI CMSN. Implementation tasks include:

- Assess the need for the solution in view of Recommendation #17
- Reprogram the interface between CHAS and KISS (the DCF intermediary system) or create a new interface for this purpose
- FLORIDA is modified to trigger a referral for a child leaving Medicaid
- Reprogram CHAS to generate appropriate correspondence

Benefits: An automated alternative to the 2092 form will create a faster, more efficient, and more reliable way of moving children off Medicaid and into Healthy Kids, MediKids, and Title XXI CMSN. 27,954 children were terminated from Medicaid on the basis of income during the re-determination process in 2001, including 3,869 who originally became eligible for Medicaid through the "Request for Assistance". DCF estimates 803 production hours will be saved (because of elimination of 2092 form).

Recommendation #12: Make the Child Social Security Number (SSN) a Required Data Element.

BENEFIT:	**More reliable data matches, 1.8% of applicants affected**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, 2-3 months for systems changes, 6 months for application changes**
COST:	**$9,700 (one-time)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

This change will expedite the processing of a Medicaid referral and increase the reliability and feasibility of the automated data interfaces. Implementation tasks include:

- Modify state plan amendment
- Application Workgroup reaches consensus on all changes to the application (individual changes cannot be considered in a vacuum)
- Reprogram CHAS
- Mail letter to all Title XXI enrolled families whose children lack an SSN

Benefits: This recommendation will only make a material difference to families who do not currently report the social security numbers of their applicant children. In 2001, there were 4,269 families with children enrolled in a non-Medicaid Title XXI program who lack an

SSN and who received at least one missing information letter in connection with the missing SSN (1.8% of all applicant families).

Recommendation #17: Create an Automated Data Interface Between FLORIDA and CHAS.

BENEFIT:	**Comprehensive systems improvements to reduce the likelihood of a gap in coverage for a child leaving Medicaid, significantly reduce unnecessary referrals to DCF, and eliminate duplication of effort and manual processes at DCF, affecting 43.2% of applicant children**
LEVEL OF EFFORT/ TIMEFRAME:	**Challenging, 10-12 months**
COST:	**$761,000 (one-time)**
SUBCOMMITTEE ACTION:	**Significant Support; Major Planning Required**

A well-designed and secure online interface will speed up processing times, eliminate duplication of effort, facilitate the timely transfer of data for children who are moving between programs, and provide for a common understanding regarding the business rules governing each KidCare program. Implementation tasks include:

- Articulate objectives of the interface and plan development accordingly
- Reprogram CHAS and FLORIDA and phase-out KISS
- Modify operational protocols to leverage the data that is passed between systems (some of this work is incorporated in Recommendations #18 and #19)

Benefits: The benefits of this change will be pervasive and cross many functional areas; in many cases, the positive impact of this change will be to facilitate another beneficial change or improve the system's overall reliability, neither of which can be expressed in quantifiable terms. These positive changes will affect all children referred to DCF referrals (177,336 in 2001), particularly the "false positives" that were referred to DCF and sent back to the TPA for Title XXI processing (38,925 or 22% of all DCF referrals).

Recommendation #18: Permit the Third Party Administrator to Screen for Medicaid on a More Definitive Basis and Provide Account Services to Certain KidCare Medicaid Children.

BENEFIT:	**43.2% of applicant children affected, including 9.5% of applicant children who will avoid unnecessary DCF referral**
LEVEL OF EFFORT/ TIMEFRAME:	**Challenging, concurrent with #17**

COST: **$165,000 (one-time), ongoing DHACS costs and offsetting DCF savings TBD**

SUBCOMMITTEE ACTION: **Recommends Further Study**

In the primary MAXIMUS report and in subsequent planning discussions, the Georgia "PeachCare" model was explored as an example of the approach embodied in this recommendation. In Georgia, DHACS makes more definitive Medicaid screenings subject to a *pro forma* ratification by the relevant state agency. This ratification process assumes that the DHACS determination is essentially correct and no additional contact with the family or application data entry work is necessary. The state workers primarily confirm that an applicant child is not already enrolled in Medicaid. DHACS provides account service to children enrolled in Medicaid and the state-designed SCHIP program, enabling enrollees to move seamlessly from one program to the other in much the same way that MediKids enrollees in Florida transparently graduate to Healthy Kids following their fifth birthday.

The most significant difference between the Georgia model and this recommendation is that DCF will retain account services for children who already have an active case open in FLORIDA. Implementation tasks include:

- Consult with Centers for Medicare and Medicaid Services ("CMS") regarding how DCF staff will make the final Medicaid eligibility determination
- Revise DCF Public Assistance Specialist protocols
- Amend Title XXI and Title XIX state plan amendments
- Make appropriate changes to contracts and interagency agreements
- Reprogram CHAS
- Develop an audit strategy to confirm accuracy and timeliness of Medicaid screens
- Change DCF business processes to retain KidCare referrals associated with cases already open in FLORIDA and return all other referrals to DHACS for account maintenance
- Develop new DHACS correspondence templates

Benefits: This recommendation will greatly reduce or eliminate "false positive" referrals and provide a foundation for smooth transitions between all KidCare programs for children who enter the process through a KidCare application. It will also mitigate the negative consumer experience that currently occurs when a family calls the TPA's hotline not realizing its application has been referred to DCF. These positive changes will affect all children referred to DCF referrals (177,336 in 2001), particularly the "false positives" that were referred to DCF and sent back to the TPA for Title XXI processing (38,925 or 22% of all DCF referrals).

Recommendation #19: The Medicaid Re-determination Process Should be Re-Engineered.

BENEFIT: **Around 28,000 children per year less likely to experience gap in coverage**

LEVEL OF EFFORT/

TIMEFRAME:	**Challenging, concurrent with #17**
COST:	**$95,000 (one-time)**
SUBCOMMITTEE ACTION:	**Significant Support; Major Planning Required**

Implementation tasks include:

- Reprogram CHAS and FLORIDA so that eligibility information for a child leaving Medicaid is sent to CHAS for a Title XXI eligibility determination
- Develop new correspondence templates for children leaving Medicaid who are referred to DHACS
- Revise the Medicaid eligibility re-determination form to include family-level and child-level information as currently stored in FLORIDA (only if Recommendation #18 is not pursued)
- Give families multiple ways to confirm or update the eligibility information (only if Recommendation #18 is not pursued)

Benefits: Re-engineering the KidCare Medicaid re-determination process will provide for a smooth and timely transition from Medicaid to Healthy Kids, MediKids, or Title XXI CMSN. 27,954 children were terminated from Medicaid on the basis of income during the re-determination process in 2001.

COROLLARY RECOMMENDATIONS

Recommendation #21: Adopt Virtual Private Network (VPN) Technology to Transfer Sensitive Client Information.

BENEFIT:	**HIPAA compliance, more secure interfaces**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, 2-3 months**
COST:	**Maximum of $4,000 (one-time) per entity (actual cost likely to be less)**
SUBCOMMITTEE ACTION:	**Recommends Approval**

The VPN approach will help the KidCare program meet the safeguard requirements in the federal Privacy Regulation § 164.530(c) (in conformity with the Health Insurance Portability and Accountability Act or "HIPAA"). VPNs should replace any current interface that is not sufficiently secure (in particular, e-mail attachments). The secure web-based interface between FMMIS and CHAS will remain "as is." The involvement of DOH is also needed. Implementation tasks include:

- Each entity surveys its current network infrastructure and obstacles to a VPN solution are identified and mitigated
- Participating entities agree on VPN protocols and connection methodologies
- VPN connections are fully tested prior to deployment

Recommendation #22: Align Medicaid and Title XXI Eligibility Rules.

BENEFIT:	**More reliable and complete integration of systems and business processes between Medicaid and Title XXI**
LEVEL OF EFFORT/ TIMEFRAME:	**Challenging, 6-8 months**
COST:	**$16,600 (one-time), $5.4 million in additional annual premium costs associated with newly eligible children**
SUBCOMMITTEE ACTION:	**Recommends Approval**

To simplify the integration of the KidCare eligibility systems and reduce the likelihood of consumer confusion, calculate family size, countable income, and income disregards for each KidCare program using the Medicaid formulas. Implementation tasks include:

- Revise Title XXI state plan amendment
- Application Workgroup agrees on necessary changes
- Reprogram CHAS
- Re-engineer Title XXI renewal process to collect new information germane to the Title XIX eligibility parameters
- Acknowledge that alignment creates the opportunity of FLORIDA being the single KidCare eligibility system and consider this option within the context of pending state agency and legislative initiatives

Recommendation #24: Change How CHAS Generates Correspondence.

BENEFIT:	**9.4% of families avoid receiving multiple missing info letters**
LEVEL OF EFFORT/ TIMEFRAME:	**Easy, 2-3 months**
COST/SAVING:	**$4,100 (one-time cost), $10,000 annual savings**
SUBCOMMITTEE ACTION:	**Recommends Approval**

CHAS should be changed to eliminate the generation of multiple missing information letters going out to the same family. This recommendation does not involve DCF or AHCA. The primary task is revising the correspondence template to contain all missing information elements.

Recommendation #28: More Systematic Communication Among the KidCare Partners.

BENEFIT:	**More productive interactions and more collaborative planning among KidCare partners**

LEVEL OF EFFORT/
TIMEFRAME: **Easy, one month**
COST: **N/A**
SUBCOMMITTEE ACTION: **Recommends Approval**

The KidCare partners should agree on a systematic, routine, and timely communications protocol involving relevant leadership and staff so that major policy changes and communication initiatives occur with the understanding of all the key players. This recommendation also requires the involvement of DOH.

DISPOSITION OF REMAINING RECOMMENDATIONS

Recommendation #16: Handle all KidCare Referrals at the Central Processing Units.

SUBCOMMITTEE ACTION: Recommends "Set Aside"

The goal of this recommendation was to speed the processing of children whose families already have a case open within FLORIDA. During 2001, approximately 16,000 applications were referred to district offices. The district-processed applications were finished an average of 1.6 days sooner than those completed in the CPUs. Therefore, it does not appear that a change in this process is warranted or advisable.

Recommendation #23: Additional Application Changes. This recommendation was incorporated into #13(a) and #13(b)

Recommendation #27: Evaluate Optical Character Recognition (OCR) for Data Entry.

SUBCOMMITTEE ACTION: Recommends "Set Aside"

Accuracy rates associated with OCR are not consistent with the DHACS performance data entry accuracy standard of 98%. To meet this standard under an OCR approach, 100% of applications would require manual quality assurance, which would defeat the purpose of this recommendation, which is increased cost-effectiveness and reduced processing time.

Eligibility Improvement Process Phase II Meetings & Conference Calls Participants

April 29 & 30 Meetings

Randy Fritz, MAXIMUS
Peggy Comer, AHCA
Joyce Raichelson, AHCA
Danni Atkins, CMSN
Bob Bardes, CMSN
Nancy Donovan, DCF
Linda Ginn, DCF
David Jo, DHACS
Augie Lopez, DHACS
Peg Moster, DHACS
Jay Wells, DHACS
Jennifer Betts, FHKC
Yolanda Cope, FHKC
Lisa Gill, FHKC
Shannon Grooters, FHKC
Samone Hunter, FHKC
Paula Kiger, FHKC
Rose Naff, FHKC
Bridgett Singleton, FHKC
Merrio Tornillo, FHKC
Nancy Moreau, Florida Pediatric Society
Dan Griffin, Chiles Center
Anita Zervigon-Hakes, Chiles Center

May 3, 2002 Conference Call (Recommendations #3 & #10)

Randy Fritz, MAXIMUS
Bob Bardes, CMSN
David Jo, DHACS
Augie Lopez, DHACS
Jay Wells, DHACS
Yolanda Cope, FHKC
Paula Kiger, FHKC

(Phyllis Sloyer, CMSN, was briefed individually after the call.)

May 6, 2002 Conference Call (Recommendation #18)

Randy Fritz, MAXIMUS
Nancy Donovan, DCF
Linda Ginn, DCF
David Jo, DHACS
Augie Lopez, DHACS
Peg Moster, DHACS
Jay Wells, DHACS
Yolanda Cope, FHKC
Paula Kiger, FHKC

May 7, 2002 Meeting/Conference Call (Recommendation #26)

Randy Fritz, MAXIMUS
Danni Atkins, CMSN
Brian Brooker, CMSN
Don Meyer, CMSN
Peggy Comer, AHCA
Pat Garrett, AHCA
David Powers (Medicaid Contract Management/AHCA)
Tom Rice (MediPass/AHCA)
Linda Ginn, DCF
Jennifer Betts, FHKC
Lisa Gill, FHKC
Paula Kiger, FHKC
Rose Naff, FHKC
Bridgett Singleton, FHKC
Merrio Tornillo, FHKC

May 10, 2002 Conference Call (Recommendation #7)

Peggy Comer, AHCA
Randy Fritz, MAXIMUS
Paula Kiger, FHKC

May 10, 2002 Conference Call (Recommendation #17)

Randy Fritz, MAXIMUS
LaQuetta Anderson, DCF
Kim Brock, DCF
Nancy Donovan, DCF
Patti Swann, DCF
Val Taylor, DCF
Paula Kiger, FHKC

May 13 –15 Meetings

Randy Fritz, MAXIMUS
Cheryl Travis, ACS
Peggy Comer, AHCA

Dennis Eskew, AHCA
Alan Strowd, AHCA
Phyllis Sloyer, CMSN
Nancy Donovan, DCF
Linda Ginn, DCF
Patti Swann, DCF
David Jo, DHACS
Augie Lopez, DHACS
Jay Wells, DHACS
Jennifer Betts, FHKC
Yolanda Cope, FHKC
Samone Hunter, FHKC
Rose Naff, FHKC
Dr. Louis St. Petery, FHKC (Board Member)
Merrio Tornillo, FHKC
Gail Vail, Chiles Center

May 16, 2002 Conference Call (Recommendation #21)

Randy Fritz, MAXIMUS
Peggy Comer, AHCA
Mike Boston, EDI, ACS
Mannix Hawkins, ACS
Gay Munyon, ACS
Amy O'Kelley, EDI, ACS
Gigi Pascual, ACS
Suzanne Smith, ACS
Sam Sheffield, EDI, ACS
Paula Kiger, FHKC

Revised 5/28/02 2:55 p.m.