IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Petitioners,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Respondents.
_____/

EXHIBIT INDEX

Ex. No.	Ex. Name
1	Fla. Healthy Kids Corp. (FHKC), "Florida KidCare, About: Cost," https://www.floridakidcare.org/cost/ (last visited Feb. 25, 2026)
2	Fla. Agency for Health Care Admin. (AHCA), "Children's Health Insurance Program Eligibility Extension, Section 1115 Title XXI Research Demonstration, New 5-Year Demonstration Request" (March 20, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-chip-elig-03202024-pa.pdf
3	AHCA, "Implementation Update to the House Select Committee on Health Innovation" (Oct. 16, 2023), https://flhouse.gov/Sections/Documents/loaddoc.aspx?MeetingId=14008&PublicationType=Committees&DocumentType=Meeting%20Packets

4	U.S. Dep't of Health and Human Servs., Office of the Assistant Sec'y for Planning and Educ., "2026 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)" https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf (last visited Feb. 25, 2026)
5	State of Florida, Florida KidCare Program, Amendment to Florida's Title XXI Child Health Insurance Plan, Amendment FL-22-00340-CHIP (March 11, 2021) https://ahca.myflorida.com/content/download/22249/file/Complete_FL_CHIP_State_Plan_07132022.pdf
6	Audio Transcription: FHKC presentation to Senate Appropriations Committee on Health and Human Services (Oct. 11, 2023) Video Recording available at: https://www.flsenate.gov/media/VideoPlayer/4355 (Transcript begins at 57:18)
7	Audio Transcription: Joint AHCA/FHKC presentation House Select Committee on Health Innovation (Oct. 16, 2023) Video Recording available at: https://www.flhouse.gov/VideoPlayer.aspx?eventID=9022 (Transcript begins at 22:05)
8	Letter from Angela D. Garner, Deputy Dir. for Dir. Div. of System Reform Demonstrations, Center for Medicaid & CHIP Servs., to Tom Wallace, Deputy Sec'y for Health Care Finance and Data, AHCA (March 8, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-chldrn-hlth-insure-prgrm-elgblty-extnsn-cms-incmptns-lter.pdf
9	Letter from Lisa Marunyez on behalf of Deputy Dir. for Dir. Div. of System Reform Demonstrations, Center for Medicaid & CHIP Servs., to Tom Wallace, Deputy Sec'y for Health Care Finance and Data, AHCA (March 28, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-chip-elig-cms-compltns-ltr.pdf
10	Letter from Chiquita Brooks-Lasure, Adm'r, Centers for Medicare and Medicaid Servs. (CMS), to Brian Meyer, Deputy Sec'y for Medicaid, AHCA (Dec. 2, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-chip-elig-ca.pdf

11	Email exchange between Brian Meyer, Deputy Sec'y for Medicaid, AHCA and Daniel Tsai, Deputy Adm'r & Dir., Ctr. for Medicaid & CHIP Servs. (Dec. 2, 2024 thru Jan. 15, 2025)
12	Letter from Daniel Tsai, Deputy Adm'r & Dir., Ctr. for Medicaid & CHIP Servs., to Brian Meyer, Deputy Sec'y for Medicaid, AHCA (Jan. 17, 2025) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-chip-elig-ltr-to-st-01172025.pdf
13	CMS, Medicaid.gov, Section 1115 Demonstrations, State Waivers List, Florida Children's Health Insurance Program Eligibility Extension, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/162076
14	Letter from Karen Llanos, Acting Director, State Demonstrations Group, CMS, to Brian Meyer, Deputy Sec'y for Medicaid, AHCA (June 25, 2025) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-chip-elig-extns-monitor-redesgn-overlay-ltr.pdf
15	Audio Transcription: AHCA presentation to Senate Committee on Health Policy (Oct. 7, 2025) Video Recording available at: https://www.flsenate.gov/media/VideoPlayer/5670 (Transcript begins at 1:05:41)
16	Letter from Chiquita Brooks-Lasure, Adm'r CMS, to Brian Meyer, Deputy Sec'y for Medicaid, AHCA (Jan. 2, 2025)
17	Declaration of Joceyln Durant
18	Declaration of Rebbeca Morris

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_____/

EXHIBIT 1

"Florida KidCare, About: Cost"

Florida KidCare

Affordable Coverage

Florida KidCare coverage is income-based and offers options for all income levels. Most families pay nothing at all and many pay as little as $15 or $20 per month.

Affordable Coverage

Florida KidCare coverage is income-based and offers options for all income levels. Most families pay nothing at all and many pay as little as $15 or $20 per month.

Cost

Monthly payment costs are based on a child's age, household size and adjusted gross annual income. Florida KidCare coverage is available to families at all income levels.

Medicaid

$0
per month

CHIP Subsidy

$15 or $20
per month

Full-Pay

$248.21 or
$276
per month
per child

Some families will qualify for low-cost Florida KidCare coverage through the Children's Health Insurance Program (CHIP). With CHIP, the government pays part of your monthly payment amount. This is called a subsidy. The government decides who qualifies for CHIP coverage, based on a formula called the federal poverty level. The federal poverty level is used to determine who qualifies for many public programs.

Children in families with household incomes between 133% and 200% of the federal poverty level qualify for CHIP coverage. Families who qualify for CHIP coverage pay just $15 or $20 per month to cover all eligible children in the household. Families earning more qualify for other Florida KidCare options.

Children who don't qualify for CHIP may qualify for other Florida KidCare coverage called full-pay. The Florida Healthy Kids and MediKids plans both offer full-pay coverage. Full-pay coverage has the same benefits as CHIP, but you pay the full monthly payment amount every month for each covered child because there is no subsidy. Currently, there is no full-pay option for the CMS Health Plan.

Some health care services require a small additional fee called a copay. When required, copays are never more than $10. Unlike many other health plans, there is no deductible with Florida KidCare. With affordable monthly payments and little to no copays, there are no hidden fees or unexpected costs. Our goal is to ensure all Florida's children have access to the services they need when they need them.

Florida KidCare will automatically match children with the best fit Florida KidCare program.

Florida KidCare

Estimate Your Cost

If you're interested in applying for Florida KidCare coverage for your child(ren), use this simple cost calculator to estimate what your monthly premium payment would be.

Cost Calculator

+
Español Kreyol
ayisyen

Contact Us
Board of Directors
Media

Partner Resources
Notices
Required Reporting

Follow Us

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_____/

EXHIBIT 2

"Children's Health Insurance Program Eligibility Extension, Section 1115 Title XXI Research Demonstration, New 5-Year Demonstration Request"

RON DESANTIS
GOVERNOR

February 23, 2024

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue Southwest
Washington, DC 20201

Dear Secretary Becerra:

Florida seeks to implement a five-year Section 1115 Research and Demonstration Waiver for the Children's Health Insurance Program (CHIP). Florida's CHIP, called Florida KidCare, provides health insurance for uninsured children in families with incomes up to 200 percent of the federal poverty level. CHIP is not an entitlement program, and families pay monthly family premiums depending on the family's income.

This waiver seeks to increase income eligibility up to 300 percent of the federal poverty level and to update and add monthly premium tiers to align with the increase in eligibility to higher income families.

Please find enclosed documentation as required in 42 CFR 431.412 to support this request. We appreciate your efforts in working with our State to implement the necessary federal authorities.

Sincerely,

[redacted]

Ron DeSantis
Governor

Enclosure

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

Children's Health Insurance Program Eligibility Extension

Section 1115 Title XXI Research Demonstration

New 5-Year Demonstration Request

Florida Agency for Health Care Administration

Contents

Program Application Overview

The Florida Agency for Health Care Administration (AHCA) is seeking federal authority from the Centers for Medicare & Medicaid Services (CMS) to implement a new section 1115 (Title XXI) Children's Health Insurance Program (CHIP) demonstration that offers program eligibility to children with family income above 200 percent of the federal poverty level (FPL)[1], up to 300 percent of the FPL, with enrollment subject to monthly premiums. This section 1115 demonstration will operate concurrently with the CHIP state plan which offers health insurance for uninsured children in families with incomes up to 200 percent of the FPL. The state is requesting authority for new premium amounts through this demonstration for all CHIP eligible recipients included in both the CHIP state plan and the section 1115 waiver authorities with incomes between 133 and 300 percent of the FPL. The State is seeking a proposed effective date of April 2024.

I. Demonstration Purpose, Goals, and Objectives and CHIP Program Overview

Demonstration Purpose, Goals, and Objectives

Florida is focused on ensuring that families have Pathways to Prosperity, which are individualized paths to prosperity, economic self-sufficiency, and hope through community collaboration between government entities, the private sector, community organizations, and the nonprofit sector. The Florida Legislature and Governor DeSantis recognized that parents who are working hard to improve their economic situation of their family could potentially lose access to subsidized CHIP health insurance for their children through even a small increase in their income, and that the potential loss of the subsidized coverage could be a disincentive to the parent in their pathway to prosperity and economic self-sufficiency. For example, a parent who worked more hours or received a promotion that increased annual income by $300 (approximately 1% of the FPL for a family of four with two children) would face an increase in premiums from subsidized CHIP coverage (with premiums of $240 per year per family) to $5,748 annually if they chose to participate in Florida's full-pay program.

In response, the Florida Legislature passed House Bill 121 (HB 121), signed into law in June 2023, to increase eligibility for the CHIP-subsidized KidCare programs above the current state plan threshold of 200 percent of the FPL up to 300 percent of the FPL. HB 121 also requires the State to establish new monthly premiums for CHIP enrollees. The new premium structure creates a graduated level of premiums that allows families with growing income to be able to continue to afford health insurance for their children.

This proposed demonstration is critical at this time as Florida's economy thrives, and more families are reporting increased income levels above those allowed for Florida Medicaid eligibility.

Florida's Medicaid redetermination process is already projected to increase enrollment in Florida's KidCare Full-Pay program, as current Medicaid enrollees with income levels too

[1] 200 percent represents the percent of the FPL prior to the application of the modified adjusted gross income (MAGI) conversion.

high for Medicaid and too high for CHIP-subsidized KidCare disenroll and look for other coverage options. Florida estimates 16,328 children with household incomes under 300% FPL will enroll in Full-Pay KidCare in Fiscal Year 2023-2024.

This proposed demonstration is expected to enable Florida to continue to make strides in increasing access to creditable health insurance coverage for lower-income children within the State while supporting increased economic self-sufficiency and pathways to prosperity. Accordingly, the goals and objectives of this demonstration are to:

- Increase enrollment and access to CHIP-subsidized coverage; and,

- Improve or maintain the rate of uninsured children under age 19 in the State of Florida.

CHIP Background

The Florida KidCare Program (KidCare or Program) was created by the Florida Legislature in 1998 in response to the passage of the federal Children's Health Insurance Program (CHIP) in 1997. The federal CHIP provides funding for states who choose to subsidize health insurance coverage to uninsured children in families with incomes that are too high to qualify for Medicaid but who meet other eligibility requirements. Florida's KidCare program encompasses four partner programs, that together with the availability of full-pay options for those who do not qualify for subsidized coverage matched by the federal government, offers coverage for all children in the State of Florida. The four programs that comprise Florida KidCare are:

1. **Medicaid for children** – Title XIX medical coverage to eligible children up to 1-year-old with family income that does not exceed 200 percent of the FPL and to eligible children, ages 1-18, with family income that does not exceed 133 percent of the FPL.

2. **MediKids Program** – MediKids provides low-cost health insurance for children ages 1 through 4. The MediKids program is similar to Medicaid. Children enrolled in the MediKids program receive medical services and benefits from Medicaid providers through Medicaid's Managed Medical Assistance (MMA) program. The program charges monthly premiums but does not impose any other form of beneficiary cost-sharing (i.e., no deductibles, co-payments, or coinsurance).

3. **Children's Medical Services (CMS)** – CMS is a collection of programs that provides a statewide managed care system for children (under age 19) with special health care needs and provides essential preventive, evaluative, and early intervention services for at-risk children.

4. **Florida Healthy Kids Program** – Florida Healthy Kids offers quality, affordable, child-centered health and dental insurance for children ages 5 through 18. Florida Healthy Kids has a subsidized plan for families who exceed the income eligibility

threshold for Medicaid, as well as full-pay options for those who do not qualify for subsidized coverage.

KidCare is governed by part II of Chapter 409, Florida Statutes (F.S.) and is administered jointly by AHCA, the Department of Children and Families, the Department of Health, and the Florida Healthy Kids Corporation (Corporation) established in Chapter 624, F.S. Table 1 below delineates the roles of each agency and the Corporation:

Table 1: Florida KidCare Organizational Structure

State Agency and Program(s)	Responsibilities
Agency for Health Care Administration (AHCA) (MediKids)	• Administers the Medicaid program (Title XIX) • Administers the MediKids program (Title XXI, ages 1-4) • Serves as lead Title XXI contact with the federal Centers for Medicare and Medicaid Services • Distributes federal funds for Title XXI programs • Manages the Florida Healthy Kids Corporation contract • Develops and maintains the Title XXI Florida KidCare State Plan
Department of Children and Families (DCF) (Medicaid for Children)	• Determines Medicaid (Title XIX) eligibility • Administers the CMS Behavioral Health Network (Title XXI, ages 0-18)
Department of Health (Children's Medical Services)	• Administers Children's Medical Services (Titles XIX and XXI, ages 0-18 with special health care needs)
Florida Healthy Kids Corp. (Healthy Kids)	• Performs administrative functions for Florida KidCare (eligibility determination, premium collection, marketing, and customer service) • Administers Florida Healthy Kids program (Title XXI, ages 5-18)

II. Demonstration Benefits, Eligibility and Cost-Sharing

Benefits

Florida KidCare health and dental services are delivered through quality plans that offer a choice of local doctors, dentists, specialists, hospitals, pharmacies, and other health care providers. Florida KidCare benefits minimally include but are not limited to: doctor visits, surgeries, check-ups, immunizations, dental and vision care, prescriptions, hospital stays, behavioral health, and emergencies.

Eligibility

Eligibility for Florida KidCare, including Florida Healthy Kids, is determined in part by age and household income, as a percent of the FPL, as indicated in Table 2 below:

Table 2 – Florida KidCare Eligibility and Cost-sharing Structure

Program	Ages	Family Income Eligibility			Existing Monthly Premium Structure	Copay (some services)
		FPL Threshold (Pre MAGI)	FPL Threshold (Post MAGI)	Annual Income[2]		
Medicaid for Children	0-1	185-200% FPL	194-210% FPL	$55,000 – $60,000	$0	$0
MediKids	1-4	133-200% FPL	140-210% FPL	$41,400 – $60,000	$15 for 133-158% FPL $20 for 158-200% FPL (per household)	Up to $10
Healthy Kids	5	133-200% FPL	140-210% FPL	$41,400 – $60,000		Up to $10
	6-18	100-200% FPL	112-210% FPL	$30,000 – $60,000		Up to $10
Children's Medical Services	0-18	Up to 200% FPL	Up to 210% FPL	$0 – $60,000		$0
Full-Pay (MediKids & Healthy Kids)	1-18	Over 200% FPL	Over 210% FPL	Over $60,000	$210 - MediKids $259 - Healthy Kids (per child)	$10 or $15

The demonstration will not change CHIP state plan eligibility for uninsured children in households with income up to the threshold of 200 percent of the FPL. The CHIP state plan will continue to be the basis of eligibility for uninsured children up to and including 200 percent of the FPL.

The demonstration will be the basis of coverage for uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL. The demonstration will also be the basis of authority for the monthly premium structure that will be applied to CHIP enrollees in households with income over 133 percent of the FPL up to the new coverage threshold of 300 percent of the FPL. See Table 3 below for the proposed new monthly premium structure for the Florida KidCare program.

Cost-sharing – Monthly Premium Structure

Families contribute monthly premiums to the cost of the Florida KidCare program based on their household size, income, and other eligibility factors. The premium does not vary by the number of children in the household. In accordance with HB 121, Florida is proposing to establish new premium tiers for CHIP enrollees above 133 percent of the FPL, including the new income coverage band from above 200 percent of the FPL up to 300 percent of the FPL. The new monthly premium structure proposed for the Florida KidCare program is as follows:

[2] Annual income based on 2023 federal poverty guidelines for a family size of 4 utilizing Pre-MAGI percentages

Table 3 – Proposed New Monthly Premiums for Households[3]

Proposed Premium Tiers by Federal Poverty Level[4]					
Tier 1 FPL Range	Tier 2 FPL Range	Tier 3 FPL Range	Tier 4 FPL Range	Tier 5 FPL Range	Tier 6 FPL Range
133-175%	175-210%	210-235%	235-255%	255-275%	275-300%
$17	$30	$60	$95	$145	$195

III. Health Care Delivery System

Florida utilizes a managed care delivery system for all children enrolled in CHIP. Children in MediKids are enrolled in a Statewide Medicaid Managed Care program, Managed Medical Assistance plan. Children in Florida Healthy Kids are enrolled in one of three managed care plans contracted with the Florida Healthy Kids Corporation. Children in Children's Medical Services are enrolled in the Florida Department of Health's CMS plan. All plans are fully capitated plans that provide a comprehensive array of benefits to enrolled children.

IV. Enrollment & Expenditures

Projected Enrollment

The state's projected enrollment of uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL is listed in Table 4.

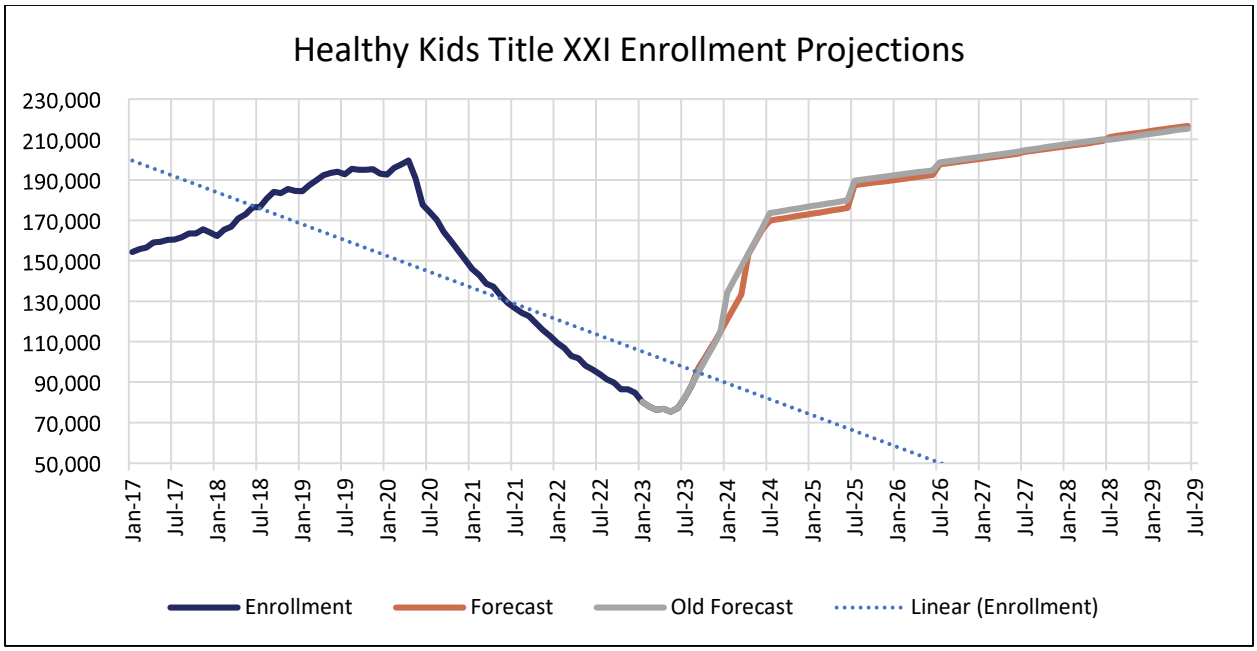
Table 4 – Projected Enrollment

DY01	DY02	DY03	DY04	DY05
14,649	28,926	38,360	41,272	41,874

Enrollment Impact

As of February 2024, 140,661 children were enrolled in KidCare. The State's 2023-2024 fiscal year projections assume that Medicaid redeterminations, which began in April 2023, will cause a growth in caseload for the KidCare program over the next year, as indicated by the graphs below.

[3] Premiums will increase by three percent each year.
[4] Tiers were adjusted prior to the public meetings to align with operational changes due to MAGI.


Healthy Kids Title XXI Enrollment Projections
230,000
210,000
190,000
170,000
150,000
130,000
110,000
90,000
70,000
50,000
Jan-17
Jul-17
Jan-18
Jul-18
Jan-19
Jul-19
Jan-20
Jul-20
Jan-21
Jul-21
Jan-22
Jul-22
Jan-23
Jul-23
Jan-24
Jul-24
Jan-25
Jul-25
Jan-26
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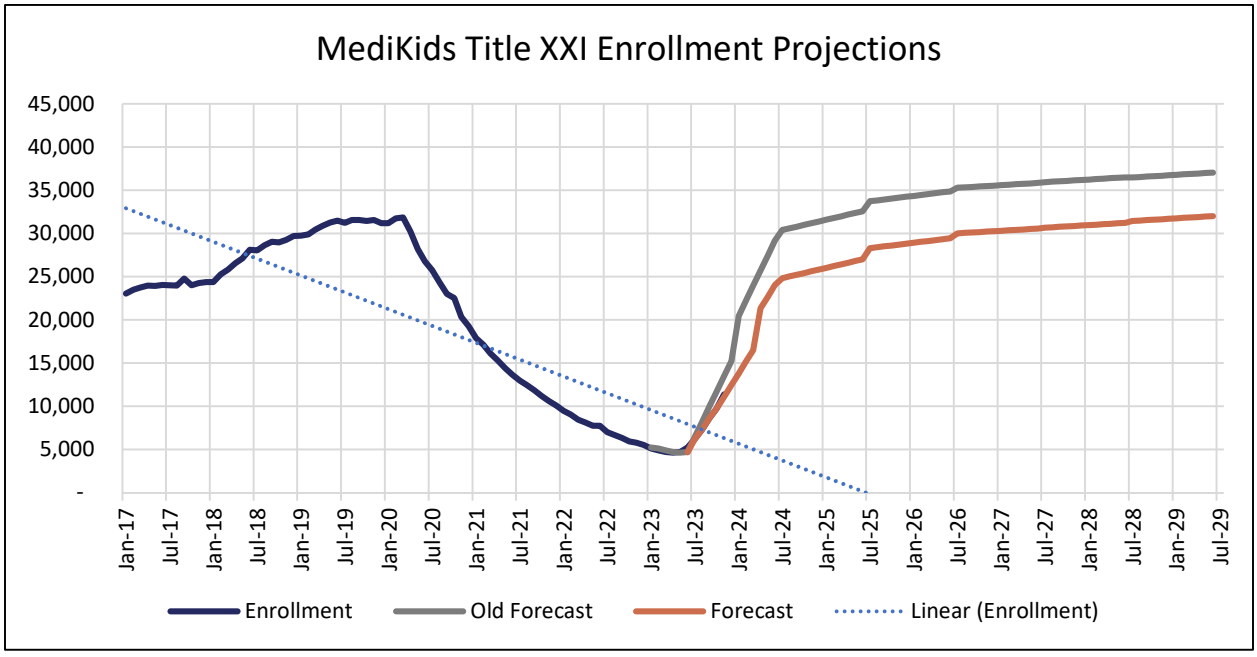
Jan-28
Jul-28
Jan-29
Jul-29
Enrollment
Forecast
Old Forecast
Linear (Enrollment)


MediKids Title XXI Enrollment Projections
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
Jan-17
Jul-17
Jan-18
Jul-18
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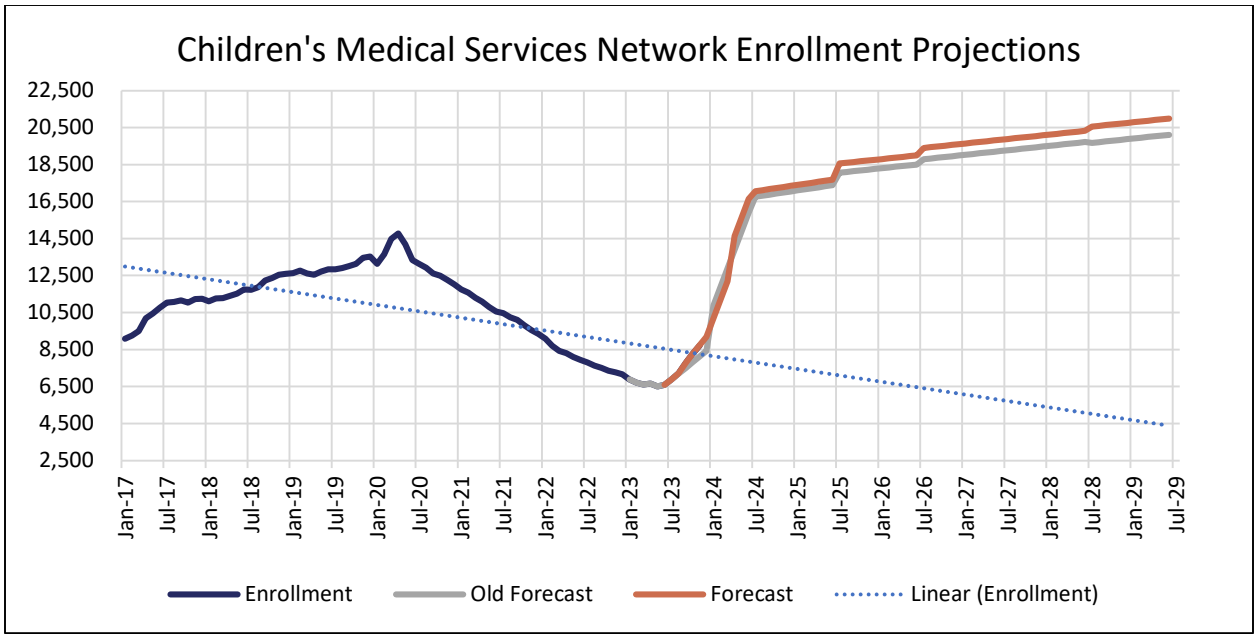
Jan-28
Jul-28
Jan-29
Jul-29
Enrollment
Old Forecast
Forecast
Linear (Enrollment)



Florida's current work to complete Medicaid redeterminations in the post public health emergency return to normal operations per CMS guidance, has resulted in an estimated 16,328 children in Fiscal Year 2023-2024 with household income under 300% FPL who would only be eligible for enrollment in Full-Pay KidCare at an approximate annual premium of $3,114 plus nominal co-pays for certain services. The proposed demonstration will increase the upper eligibility band for KidCare eligibility, thereby making many Full-Pay KidCare enrollees now eligible for (more affordable) subsidized-KidCare coverage. Accordingly, the proposed demonstration is expected to impact projected overall CHIP enrollment by increasing the number of lower-income uninsured children eligible for enrollment in KidCare by approximately 165,000 children over the initial five years of implementation.

This new premium structure is not expected to impact general disenrollment trends or processes. Total projected enrollment in KidCare, including disenrollments due to failure to pay the monthly premium, was utilized to calculate the total costs for the demonstration.

Historical Expenditures

The state's historical medical assistance expenditures for coverage of uninsured children with household income ranging from above 133 percent of the FPL up to 200 percent of the FPL are listed in Table 5.

Table 5 - Expenditure History

FFY 18-19	FFY 19-20	FFY 20-21	FFY 21-22	FFY 22-23
$ 496,675,888	$ 504,716,531	$ 397,374,075	$ 318,181,593	$ 298,635,527

Projected Expenditures

The state's projected medical assistance expenditures for coverage of uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL is listed in Table 6.

Table 6 – Projected Title XXI (CHIP) Expenditures

DY01	DY02	DY03	DY04	DY05
$16,999,053	$69,794,099	$106,984,015	$125,152,604	$135,457,940

The title XXI CHIP allotment neutrality analysis workbook for this 5-year request is provided as a separate attachment to this application.

V. Evaluation Parameters

The State, in consultation with a to-be selected evaluator, will identify validated performance measures that will assess the impact of the demonstration on CHIP enrollees. In addition, the State intends to work with the selected evaluator to identify meaningful comparison groups in designing the evaluation plan. It is the intent of the State to follow all CMS evaluation design guidance in working with the State's selected evaluator to draft an evaluation plan. See the proposed evaluation parameters in Table 7 below.

Table 7 – Proposed Evaluation Parameters

Proposed Hypothesis	Anticipated Measure(s)	Proposed Data Sources
The demonstration will increase enrollment and access to CHIP coverage.	Number of children with family income over 200% of FPL up to 300% of FPL enrolled in CHIP.	Florida CHIP claims and enrollment records
The demonstration will improve or maintain the rate of uninsured children under age 19 in the State of Florida.	Reported uninsurance rates: Number of children up to age 19 in Florida without health coverage	U.S. Census Bureau Data, American Community Survey (ACS)

VI. Waiver and Expenditure Authorities

Table 8 – Proposed Waiver and Expenditure Authorities

Section 1115(a)(1) Waiver Authorities	*Florda does not anticipate needing any waivers of the provisions under Title XXI of the Social Security Act to implement this demonstration.*
Section 1115(a)(2) Expenditure Authorities	Expenditure authority to offer CHIP coverage (through Florida KidCare) to uninsured children in households with income above 200 percent of the FPL up to 300 percent of the FPL.
	Expenditure authority to implement a monthly premium structure to be imposed on CHIP enrollees with income above 133 percent of the FPL up to 300 percent of the FPL as a condition of enrollment.

VII. Documentation of State Public Notice Process

The abbreviated notice was published on January 23, 2024 via Florida Administrative Register. Notice for tribal consultation was sent on January 23, 2024 to the Miccosukee and Seminole Tribes via email. As outlined in these public notices, AHCA provided a 30-day public comment period from January 23, 2024 at 3:00 pm EST, through February 21, 2024 at 3:00 pm EST. The draft section 1115 demonstration application and related public notice materials were posted for the minimum 30-day public comment period starting January 23, 2024 at 3:00 pm EST, on the Federal Waivers Home page located on the AHCA website: https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers.

In addition to publishing notices, AHCA conducted two public meetings on the proposed application as outlined in the State's published public notices. These meetings were held:

Public Meeting 1:
Wednesday, January 31, 2024, 11:00 am – 12:00 pm EST
Medical Care Advisory Committee Meeting
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308
Audio: (850) 792-4898, Phone Conference ID: 324 032 061#

Public Meeting 2:
February 1, 2024, 1:00 pm – 2:00 pm EST
DMS Orlando North Tower Conference Room
400 W. Robinson St., Suite N109
Orlando, FL 32801

The rest of this page intentionally left blank

Tribal Notifications

1115 Waiver Request - Children's Health Insurance Program Eligibility Extension

Reply | Reply All | Forward | ...

Tue 1/23/2024 7:19 PM

QK Quinn, Kimberly
To CassandraO@miccosukeetribe.com

Children's Health Insurance Program Eligibility Extension Request.pdf
.pdf File

Dear Ms. Osceola:

The Florida Agency for Health Care Administration (AHCA) intends to submit to the Centers for Medicare & Medicaid Services (CMS) a request for a new title XXI section 1115 demonstration to offer income eligibility for the state's Children's Health Insurance Program (CHIP) up to 300 percent of the federal poverty level (FPL) with premium requirements. The new demonstration will be called the "Children's Health Insurance Program Eligibility Extension." The purpose of this notice is to solicit comments from the Miccosukee Tribe of Florida.

Florida's CHIP, called Florida KidCare, provides health insurance for uninsured children in families with incomes up to 200 percent of the federal poverty level. CHIP is not an entitlement program, and families pay monthly family premiums depending on the family's income.

AHCA is proposing to offer CHIP program eligibility to children with family income above 200 percent of the FPL, up to 300 percent of the FPL, with enrollment subject to monthly premiums. The new monthly premium amounts that will be implemented as a condition of CHIP coverage are listed in the below table.

Proposed Premium Tiers by Federal Poverty Level					
Tier 1 FPL Range	Tier 2 FPL Range	Tier 3 FPL Range	Tier 4 FPL Range	Tier 5 FPL Range	Tier 6 FPL Range
133-175%	175-200%	200-225%	225-250%	250-275%	275-300%
$17	$30	$60	$95	$145	$195

To make comments on the draft final application (included with this communication) or to request additional information on the proposed new demonstration request, please contact Kimberly Quinn by phone at (850) 412-4277 or email at Kimberly.Quinn@ahca.myflorida.com. You have 30 days from the receipt of this notice to submit comments on the proposed demonstration application, otherwise we will assume that you have no comments.

Thank you!

Kim

Kimberly Quinn – Deputy Bureau Chief
Bureau of Medicaid Policy

Bldg 3, Rm 2320
2727 Mahan Drive, Mailstop 20
Tallahassee, FL 32308
+1 850-412-4277 (Office)
Kimberly.Quinn@ahca.myflorida.com

REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTE FRAUDE DE MEDICAID

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1115 Waiver Request - Children's Health Insurance Program Eligibility Extension

QK Quinn, Kimberly
To Vandhana Kiswani

Reply | Reply All | Forward | ...
Tue 1/23/2024 7:23 PM

Children's Health Insurance Program Eligibility Extension Request.pdf
.pdf File

Dear Dr. Kiswani-Barley:

The Florida Agency for Health Care Administration (AHCA) intends to submit to the Centers for Medicare & Medicaid Services (CMS) a request for a new title XXI section 1115 demonstration to offer income eligibility for the state's Children's Health Insurance Program (CHIP) up to 300 percent of the federal poverty level (FPL) with premium requirements. The new demonstration will be called the "Children's Health Insurance Program Eligibility Extension." The purpose of this notice is to solicit comments from the Seminole Tribe of Florida.

Florida's CHIP, called Florida KidCare, provides health insurance for uninsured children in families with incomes up to 200 percent of the federal poverty level. CHIP is not an entitlement program, and families pay monthly family premiums depending on the family's income.

AHCA is proposing to offer CHIP program eligibility to children with family income above 200 percent of the FPL, up to 300 percent of the FPL, with enrollment subject to monthly premiums. The new monthly premium amounts that will be implemented as a condition of CHIP coverage are listed in the below table.

Proposed Premium Tiers by Federal Poverty Level					
Tier 1 FPL Range	**Tier 2 FPL Range**	**Tier 3 FPL Range**	**Tier 4 FPL Range**	**Tier 5 FPL Range**	**Tier 6 FPL Range**
133-175%	**175-200%**	**200-225%**	**225-250%**	**250-275%**	**275-300%**
$17	$30	$60	$95	$145	$195

To make comments on the draft final application (included with this communication) or to request additional information on the proposed new demonstration request, please contact Kimberly Quinn by phone at (850) 412-4277 or email at Kimberly.Quinn@ahca.myflorida.com. You have 30 days from the receipt of this notice to submit comments on the proposed demonstration application, otherwise we will assume that you have no comments.

Thank you!

Kim

Kimberly Quinn – Deputy Bureau Chief
Bureau of Medicaid Policy

Bldg 3, Rm 2320
2727 Mahan Drive, Mailstop 20
Tallahassee, FL 32308
+1 850-412-4277 (Office)
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VIII. Public Comments

The Agency carefully considered all comments received on the proposed waiver. No changes were made to the waiver request in response to submitted comments. A summary of comments is included below, and copies of the comments received are included with the submission of this application:

Summary of Comments 1115 CHIP ELIGIBILITY EXTENSION		
Comment	**Actioned (Y/N)**	**Notes**
Request for the budget neutrality workbook	Y	A copy was provided to the requestor. No changes were needed to the waiver.
Recommendation on amending goals of the demonstration	N	
Continuous coverage questions	N	
Concerns about imposing premiums and amount of premiums	N	
Recommendation on tier structure	N	
Concerns about availability of data	N	
Support for the waiver	N	
Provider enrollment question	N	

From: [redacted]
To: FLMedicaidWaivers; Noll, Austin
Subject: Children"s Health Insurance Program Eligibility Extension Request
Date: Wednesday, January 31, 2024 2:53:11 PM

Dear Mr. Noll,

This email is in follow-up to my oral comments and questions at today's public hearing on the above-referenced Section 1115 waiver.

On behalf of the Florida Health Justice Project, we are excited about the anticipated expansion of CHIP in Florida and believe it has the potential to improve access to healthcare for children in this state.

We do have some questions about the specific language of the waiver. As you suggested, I am submitting them here so the Agency can fully consider them prior to responding.

1. Would you please explain the meaning of and the reason for the second Expenditure Authority in Table 6? Specifically, what does it mean that the new premium structure is to be imposed on CHIP enrollees within the specified income categories "as a condition of enrollment"?

2. How does this proposed expenditure authority interact/comport with the requirement in the Consolidated Appropriations Act of 2023 that children enrolled in Medicaid and CHIP receive 12 months of continuous coverage regardless of a change in circumstances affecting eligibility, including non-payment of premiums? (More about this requirement is here).

Thank you for your consideration of these questions. Please feel free to contact me at any time if you need any clarification.

Sincerely,

Lynn

Lynn [redacted]
[redacted]
Florida Health Justice Project
[redacted]

From: [redacted]
To: FLMedicaidWaivers
Subject: Children's Health Insurance Program Eligibility Extension Request"
Date: Tuesday, January 23, 2024 5:17:48 PM

To Whom It May Concern,

As a single mother that has worked extremely hard to provide my kids a better lifestyle I often fall in a gray area where I make too much money to qualify for anything however I don't make enough to provide my daughter with disabilities valuable services that could help improve her life. Increasing the income could drastically improve the lives of children in households where parents are working to provide a quality lifestyle and simultaneously being punished for doing so. The healthcare system is drastically broken in the United States often leaving many working class families without necessary services for their children with disabilities even though their hardworking tax dollars fund many programs like this. It's imperative that we revisit program policies and adjust to keep up with inflation and societies changing needs. No family in America should have to choose between valuable healthcare services and paying the light bill. I urge you to pass this bill and increase the income guidelines to afford many working class citizens access to affordable and quality healthcare.

Thank you!

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

From: Erica L[redacted]
Sent: Wednesday, February 21, 2024 2:39 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Cc: Holly B[redacted]
Subject: 1115 Children's Health Insurance Program Eligibility Extension Request Comments
Importance: High

Hello!

Please see the attached comments and an additional resource cited in our comments.

Best,

Erica L

--

Erica [redacted] L[redacted]
[redacted]
she/her/hers
www.floridapolicy.org
[redacted]

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February 21, 2024

Jason Weida, Secretary
Agency for Health Care Administration
2727 Mahan Dr. MS #20
Tallahassee, Florida 32308
FLMedicaidWaivers@ahca.myflorida.com

VIA ELECTRONIC SUBMISSION

Re: Children's Health Insurance Program Eligibility Extension Request

Dear Secretary Weida,

Florida Policy Institute (FPI) submits these comments in response to the Agency for Health Care Administration's (AHCA's) New 5-Year Section 1115 Children's Health Insurance Program (CHIP) Demonstration Request. FPI is an independent, nonpartisan, nonprofit organization dedicated to advancing policies and budgets that improve the economic mobility and quality of life for all Floridians. We are committed to public policies which ensure that all Floridians have access to quality affordable health care.

We applaud the agency for moving forward to implement the Florida Legislature's expansion of the KidCare program. This demonstration has great potential for ensuring that children in more moderate income families do not lose coverage when their families transition into higher wage employment. However, we cannot ignore that there continue to be significant barriers for Florida children in lower income working families to obtain and keep coverage. This demonstration should also focus on improving enrollment and continuous coverage for these children. We support federal approval of this waiver, but as further described below, we urge the agency to take specific actions to address these concerns.

"Maintaining the rate of uninsured" is not a proper goal for a section 1115 demonstration

One of the stated goals of the demonstration as specified in the section 1115 application is to "[i]mprove or maintain the rate of uninsured children under age 19 in the state of Florida." (p. 2). We urge the state to eliminate maintaining the rate as one of its goals. Florida is ranked 46th in the country for the percentage of its children who are uninsured. This demonstration must be consistent with the overall statutory objectives of CHIP — to enable states to "initiate and expand provision of child health insurance to uninsured low-income children..." 42 U.S.C. s.1397aa(a).

There has been a substantial enrollment decline in CHIP since the end of the COVID-19 pandemic. In June 2019, Florida's subsidized KidCare enrollment was about 230,000. By October 2023 it had decreased to about 119,000. (See attached Declaration of Austin Noll, Deputy Secretary Medicaid.) This demonstration provides the state an opportunity to test new strategies for increasing enrollment not only in the expanded group (200 percent to 300 percent of the federal poverty limit), but also for currently eligible children with family income below 200 percent of the poverty line.

The demonstration's proposed premiums will be a hardship for many lower income Florida families

Numerous studies show that premiums are a barrier to obtaining and maintaining health insurance coverage, particularly for lower income families. This includes ALICE households (Asset Limited, Income Constrained & Employed) which are a key targeted population in this proposed demonstration. These families have income above the Federal Poverty Level (FPL) but less than what it takes to make ends meet. Lower income families are generally defined as at or below 250 percent of the FPL. This would include most of the children the demonstration proposes to cover. We are concerned that Florida's proposed premium structure will be too high for many of these families.

A recent letter from the Centers for Medicare and Medicaid Services(CMS) to Indiana about their section 1115 demonstration highlights extensive research and findings from other states' experiences with premiums. That experience shows lower initial rates of enrollment and greater disruptions in coverage due to non-payment of premiums. Even small premium charges from $1- $5 for families can be a significant burden. Notably, under Florida's proposed premium tiers, monthly premiums for the lowest income families (133 percent to 174 percent FPL) would increase from $15-$17 per month and for other families (at or below 175 percent - 200 percent FPL) premiums would increase from $20-$30 per month.

CMS' Indiana letter also references research showing that 1115 premium requirements "…may exacerbate disparities in health coverage, as historically under-resourced populations may be disproportionately affected by these policies." The letter specifically refers to findings from several states where premium policies led to decreased enrollment and shorter enrollment periods for Black beneficiaries compared to their white counterparts, and for beneficiaries with lower income compared to those with higher income. (See pp. 9-10.)

Florida data collected from a 2012 Congressionally mandated Florida CHIP evaluation shows that even under the current KidCare premium structure, thousands of children lost coverage monthly due to non-payment of premiums. (See pp. 13, 24.) More recent data from the 2022 Florida CHIP evaluation report shows that during 2022, nearly 25,000 Florida children — 20 percent — determined eligible for CHIP could not initially enroll because a premium payment was not made. (See Table 79.)

Federal policy prohibits charging premiums for children in households at or below 150 percent of the FPL. Given decades of research documenting the harmful impact of premiums on lower income households, there is nothing novel or experimental with this proposal to justify inclusion of any premium charges for these families. Indeed, quite contrary to the statutory purpose of CHIP to increase coverage, these premiums are a barrier for children to initially enroll and stay enrolled. Florida is one of a handful of states in the country that charge premiums to children at these low income ranges.

Not only is Florida one of a very few states that charges premiums to children at income levels below 150 percent of the poverty line — children in Florida are now paying more for their coverage than their parents. Through the Inflation Reduction Act, parents with income up to 150 percent of FPL can obtain silver plan coverage for zero premiums through the Healthcare.gov Marketplace.

We are also concerned about the proposed annual increases in premiums. Such annual increases have not been implemented in the KidCare program in the past. It makes no sense to include this in the proposed demonstration given the troubling data which already exists showing thousands of Florida children not enrolling or falling off the program due to non-payment. Furthermore, we question whether or not this increase in premium payment violates the current federal maintenance of effort requirements outlining that states cannot raise premiums for CHIP or Medicaid children.

Premiums add to the administrative costs of KidCare

A Kaiser Family Foundation review of multiple studies show that there are limited state savings from charging premiums and cost-sharing. Potential revenue gains are offset by increased disenrollment, increased use of more expensive services such as emergency room care and other administrative expenses. Additional studies showed that increasing premiums leads to lower-cost enrollees disproportionately dropping out, raising the average cost of the remaining insured population, and contributing to increased average medical claims. It is noteworthy that multiple states have opted to eliminate premiums in their Medicaid or CHIP programs.

Without more Florida data that includes rates of nonpayment and the administrative costs of program churn, it is unclear whether the current costs to implement premiums are offset by premium collections. This data will be even more crucial if the state proceeds with a six-tier premium structure. Families will likely experience even more confusion over premium policies, including amounts owed and the ability to re-enroll.

The proposed demonstration does not comply with federal continuous eligibility requirements

Children who have health care coverage *throughout the year* are more likely to be in better health. Twelve months continuous eligibility is a key policy for ensuring stable coverage without disruptions in care.

The Consolidated Appropriations Act of 2023 establishes a new requirement that the state provide 12 months continuous eligibility in both the Medicaid and CHIP programs starting January 1, 2024. On October 27, 2023, CMS clarified that once a child is enrolled *states will not be permitted to disenroll children for failure to pay CHIP premiums during this 12 month continuous eligibility period.*

Florida's CHIP proposal fails to incorporate this vital coverage protection. This protection is essential to successfully accomplishing the demonstration's goal of decreasing the rate of uninsured children in Florida.

The state should collect and report real-time data to help gauge the affordability of premiums

Additional data collection on the affordability of premiums will help determine whether any premium adjustments should be made over the life of the demonstration to ensure that more children are enrolled and able to keep coverage. We ask that AHCA consider providing a real-time, public facing dashboard that shows monthly CHIP application denials due to non-payment of premiums, as well as monthly disenrollments due to failure to pay premiums within the renewal period. Data collection and evaluation should be disaggregated by race, ethnicity, county, and income.

Conclusion

FPI is excited about the potential of this demonstration to significantly improve Florida's rate of uninsured children. We support approval of this application subject to the safeguards and conditions discussed above.

In sum, we urge AHCA to make the following modifications to the proposed demonstration:

- Eliminate premiums for children in households at or below 150 percent of the FPL.
- Align the proposal with federal law prohibiting termination of KidCare coverage due to non-payment of premiums during the 12-month continuous eligibility period.
- Implement rigorous real time monitoring of the demonstration, including monthly public reporting on the number of denied CHIP applications due to non-payment of the initial premium. If the state proceeds with disenrollments due to non-payment of premiums, the number of disenrollments should also be publicly reported. All this data should be disaggregated by race, ethnicity, county, and income and be posted on a public dashboard.
- Engage in ongoing robust evaluation over the lifetime of the demonstration and make modifications to the premiums as needed to ensure that more children get coverage and maintain it.

Our comments include numerous citations supporting research, including direct links to the research for AHCA's and the U.S. Department of Health & Human Services' (HHS') benefit in reviewing our comments. We direct AHCA and HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the state and federal Administrative Procedures Acts.

Thank you for the opportunity to submit these comments and please feel free to contact us if you need additional information or have questions.

Sincerely,

Erica [redacted] L
Florida Policy Institute
[redacted]

Exhibit 1

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

Case No. 8:24-cv-_____

STATE OF FLORIDA; and
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Plaintiffs,

v.

CENTERS FOR MEDICARE AND MEDICAID SERVICES; CHIQUITA BROOKS-LASURE, *in her official capacity as Commissioner of Centers for Medicare and Medicaid Services*; DEPARTMENT OF HEALTH AND HUMAN SERVICES; and XAVIER BECERRA, *in his official capacity as Secretary of Health and Human Services*,

Defendants.

DECLARATION OF AUSTIN NOLL

I, Austin Noll, declare as follows:

1. My name is Austin Noll, I am over 18 years of age, of sound mind, and capable of making this declaration. This declaration is based on my personal knowledge and other information known to the Florida Agency for Health Care Administration ("AHCA"). I believe the facts stated herein to be true and correct. I would testify to the facts stated in this declaration in open court if called upon to do so.

2. I am the Deputy Secretary for Medicaid Policy, Quality, and Operations for AHCA. In this role, I oversee the bureaus of Medicaid Policy, Medicaid Quality, Medicaid Plan Management Operations, Medicaid Recipient and Provider Assistance, and Medicaid Third Party Liability. I have held this position since February 2023. Prior to my role as Deputy Secretary, I served as the Chief Operating Officer of the Florida Healthy Kids Corporation, which operates Florida's Children's Health Insurance Program ("CHIP") under the direction of AHCA. From November 2016 to February 2023, I oversaw CHIP eligibility and enrollment, plan management operations, quality, information systems, and data analytics.

3. As of October 2023, more than 119,000 children in low- and moderate-income families statewide receive subsidized health insurance through Florida CHIP.

4. In fiscal year 2019–2020, Florida collected over $30 million in premium payments from CHIP participants.

5. On June 22, 2023, Governor DeSantis signed into law Florida H.B. 121 to substantially expand the provision of subsidized health insurance to Florida children. *See* An Act Relating to Florida KidCare Program Eligibility, H.B. 121, § 1, 2023 Leg. (Fla. 2023). Florida anticipates that its expanded CHIP plan will provide subsidized health insurance to an additional 26,096 children in its first full year.

6. Florida anticipates that the expanded CHIP will cost an additional $90 million in its first full year. That cost is expected to be funded through approximately $23.1 million in additional premium payments from families, $19.7 million in additional state funds, and $47.2 million in additional federal funds.

7. Florida anticipates collecting more than $53 million in total premium payments from new and existing CHIP participants in the first full year of the expanded CHIP.

8. In October 2023, Centers for Medicare and Medicaid (CMS) issued a Frequently Asked Questions (FAQs) that prohibits states from disenrolling CHIP participants for failure to pay premiums during the continuous eligibility period.

9. In any given month, Florida anticipates approximately 3% of Florida CHIP participants will be disenrolled for failing to pay premiums.

10. Florida anticipates that if it complies with the CMS FAQs, it will spend approximately $1 million each month to provide benefits to CHIP participants who would otherwise have been disenrolled for failing to pay premiums.

11. Disenrollments from Florida CHIP occur monthly and become effective on the first day of the month after the unpaid premium was due. The next disenrollments will be effective February 1, 2024, for participants who have not paid premiums due January 1, 2024.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 31, 2024

AUSTIN NOLL

From: FLMedicaidWaivers
To: [redacted]
Subject: FW: Comments on CHIP Eligibility Extension Waiver
Date: Wednesday, February 21, 2024 12:15:39 PM
Attachments: FHJP Comments re KidCare 1115 Waiver 02.21.24 .pdf

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[redacted] update from Ms. H[redacted]

From: Lynn H[redacted]
Sent: Wednesday, February 21, 2024 10:48 AM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: Comments on CHIP Eligibility Extension Waiver

Dear Sir or Madam,

Please see the attached letter.

Thank you.

Sincerely,

Lynn[redacted] H[redacted]
[redacted]
Florida Health Justice Project
[redacted]
[redacted]

FLORIDA HEALTH JUSTICE PROJECT

via email to FLMedicaidWaivers@ahca.myflorida.com

February 21, 2024

Agency for Health Care Administration
2727 Mahan Drive, MS #20
Tallahassee, Florida 32308

Re: Section 1115 Research and Demonstration Waiver: Children's Health Insurance Program Eligibility Extension Request

Dear Sir or Madam:

Florida Health Justice Project appreciates the opportunity to submit these comments in response to the request by the Agency for Health Care Administration (AHCA) for a new 5-Year Section 1115 Title XXI Research Demonstration Waiver.

Florida Health Justice Project (FHJP) is a nonprofit organization engaged in comprehensive advocacy aimed at expanding health care access and promoting health equity for vulnerable and marginalized Floridians. We have worked extensively on issues connected to health care coverage for Florida children in low-income families. This work includes providing training and materials as well as extensive outreach and assistance for consumers whose children may be subject to termination or have lost Medicaid during the state's post-PHE redetermination process ("the unwind") which began in April 2023. Our website contains links to the consumer and advocate materials FHJP created regarding children's eligibility for KidCare programs. A sampling of the consumers we have assisted have shared their stories on this web page (*see*, *e.g.*, Laurie and Adam).

At the outset, we want to express our appreciation of the state's intention to expand access to subsidized health insurance for children. At the same time, we also must underscore that many Florida families are currently being harmed by the ongoing delay in implementing this expansion. When House Bill 121 was passed and enacted into law on June 22, 2023, the Legislature intended it to be fully implemented as of January 1, 2024. The legislative analysis for HB 121 identified over 42,000 currently uninsured children who would benefit from the expanded eligibility of subsidized KidCare. This

number has surely risen dramatically, as since that time at least 461,000 additional children have been terminated from Medicaid through the unwinding process.[1]

There can be no question that there is a pressing need for expanded KidCare eligibility at this precise moment in time. Specifically, families with children with complex conditions, who are scheduled under Florida's Medicaid Redetermination Plan ("Plan") to undergo redetermination at the end of the unwind period, March-April 2024, have an immediate need for the expanded KidCare eligibility levels to be implemented. *See* Plan at 12. It is anticipated that a number of these children who are no longer eligible for Medicaid will need to transfer to one of the other Florida KidCare Programs. For example, Gillian's child Penelope was recently terminated from Medicaid. The family is over income for Medicaid, but they would qualify for the subsidy if/when the expansion is implemented. Gillian could have enrolled Penelope in her family's low-cost marketplace plan, but such a plan would not provide adequate coverage for a child with Penelope's complex conditions. She needs to be enrolled in a KidCare plan. The family will be struggling to pay the premium, but it is slightly less than the full cost plan available now. *See* Penelope, Chapter 2 story link.

We appreciate the opportunity to comment on certain elements of the proposed waiver, including the complex tier structure and amount of premiums, that we believe adversely impact the Legislature's intent to expand health care access to children.

While the proposed waiver application continues Florida's current policy of imposing premiums for KidCare, there is significant research showing that the imposition of premiums negatively impacts the ability of low-income individuals to obtain and maintain coverage in State Children's Health Insurance Programs (CHIP) such as KidCare.[2] This research shows that premiums in CHIP programs deter initial enrollment, shorten lengths of enrollment, and increase disenrollment of the very population the program is intended to serve. Indeed, when Florida last increased its KidCare premiums by just $5 per month, it experienced a 61% decrease in enrollment lengths in families under 150% of FPL, and a 55% decrease in enrollment length in families with incomes 150-200% of FPL.[3] Furthermore, as CMS recently addressed with

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[1] *See* Georgetown University McCourt School of Public Policy Center for Children and Families, "How many children are losing Medicaid." https://ccf.georgetown.edu/2023/09/27/how-many-children-are-losing-medicaid/

[2] *See, e.g.*, Kaiser Family Foundation (2017). The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[3] Herndon JB, Vogel WB, Bucciarelli RL, Shenkman EA. The effect of premium changes on SCHIP enrollment duration. Health Serv Res. 2008 Apr;43(2):458-77. https://doi.org/10.1111/j.1475-6773.2007.00777.x

respect to a Section 1115 Medicaid demonstration waiver pertaining to Indiana's Healthy Indiana Plan (HIP), premium requirements interfere with enrollment by causing confusion over the amounts owed, the available methods of payment, and the process and ability to re-enroll following disenrollment.[4]

In the face of this research, Florida's waiver application appears to seek to implement House Bill 121 in a manner likely to be disruptive to children's coverage. Although the legislation calls for "at least three but no more than six" premium tiers and is silent as to increases, the proposed waiver would maximize the complexity of the premium structure by having six premium tiers and imposing a three percent increase every year. We urge the state to reduce the tiers to the minimum of three tiers required by eliminating proposed Tiers 4-6. In addition to creating unnecessary complexity, the proposed premiums in these tiers are too high to be affordable for families in these income ranges. *See* Penelope, Chapter 2. For the same reasons, we oppose the proposed annual automatic increase in premium levels.

Moreover, the waiver application states that it seeks authority to implement these premiums "as a condition of enrollment" (Table 6). It is unclear whether Florida intends to require premiums only as a condition of *initial* enrollment, which is permissible, or also as a condition of *continuous* enrollment, which would contravene Section 5112 of the Consolidated Appropriations Act, 2023 (CAA). We urge AHCA to amend the waiver application to make clear that it will comply with the continuous enrollment provision of the CAA in the event of non-payment of premiums.[5]

We note that Arizona recently submitted a request for a Section 1115 Waiver to expand its CHIP program eligibility threshold from 200% to 225% of the federal poverty level, and this waiver was approved by CMS on February 16, 2024. Arizona's waiver does not impose enforceable premiums in contravention of the 2023 CAA. We urge Florida to follow Arizona's example.

Finally, as the purpose of a Section 1115 Waiver is to assist in promoting the objectives of the Social Security Act, the success of the waiver can only be measured

[4] See CMS letter to Indiana, Dec. 22, 2023 pp. 4-5: https://www.medicaid.gov/sites/default/files/2023-12/in-cms-ltr-to-the-state-12222023_1.pdf

[5] We are aware that Florida has challenged the enforceability of Section 5112 of the 2023 CAA as interpreted by the Centers for Medicare and Medicaid Services (CMS) that Section 5112 prohibits disenrollment of children from CHIP programs for non-payment of premiums. *See State of Fla. v. Centers for Medicare & Medicaid Servs.*, Case No. 8:24-cv-317 (M.D. Fla) (filed Feb. 1, 2024). This lawsuit is entirely independent of the Section 1115 waiver application process and must proceed on its own course; the state may not simply incorporate into its waiver application the relief it is seeking to achieve through litigation. Florida was well aware of CMS's interpretation of Section 5112 of the CAA (issued Oct. 27, 2024) when it initiated its waiver application (Jan. 23, 2024).

through the capture and analysis of relevant data. We urge the state to commit to greater transparency regarding its KidCare programs, including timely public release of detailed enrollment data. Given the concerns identified above regarding the potential negative effects on enrollment due to the proposed level and complexity of premiums, this published data should include at a minimum the number of children enrolled each month, differentiating between new enrollments and re-enrollments, as well as the number of monthly disenrollments including the reason for the disenrollment.

Thank you for your consideration of these written comments. We welcome the opportunity to discuss these matters with you at any time.

Sincerely,

[redacted]

Lynn [redacted]

[redacted]

Florida Health Justice Project

[redacted]

[redacted]

Miriam H[redacted]

[redacted]

Florida Health Justice Project

[redacted]

From: FLMedicaidWaivers
To: [redacted]
Subject: FW: CHIP Eligibility Extension Request - Allotment neutrality analysis
Date: Tuesday, February 13, 2024 8:47:00 AM

Please see the email below. Thank you

From: Lynn H[redacted]
Sent: Monday, February 12, 2024 4:54 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: CHIP Eligibility Extension Request - Allotment neutrality analysis

Dear Sir or Madam:

The waiver request document states at page eight that "[t]he title XXI CHIP allotment neutrality analysis workbook for this 5-year request is provided as a separate attachment to this application."

However, the referenced workbook is not included with the application nor separately posted on the website, as far as I have been able to tell.

Would you please either provide me with this analysis or a link to a website where it is publicly available?

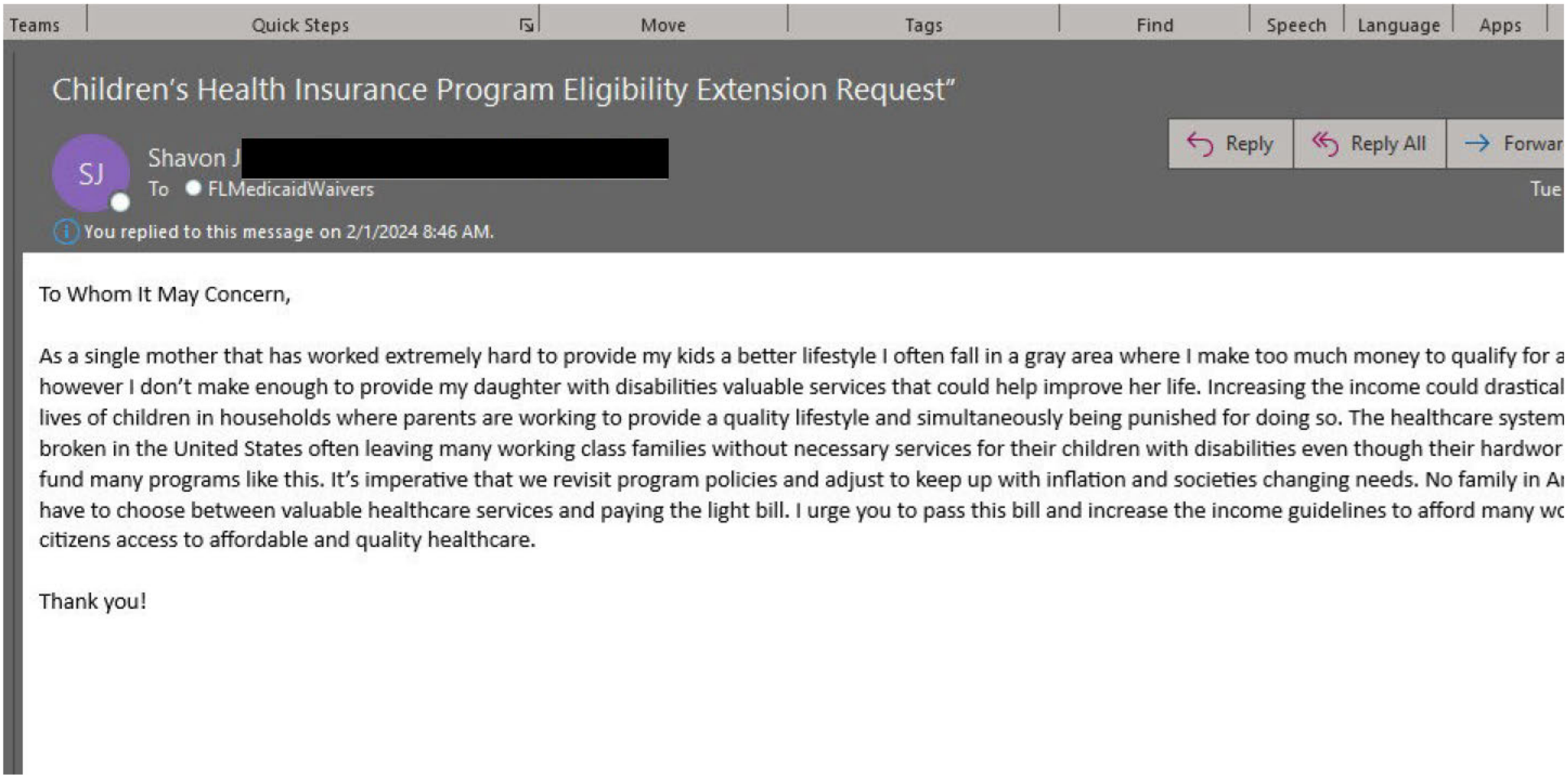
Thank you very much.

Sincerely,

Lynn [redacted] H[redacted]
[redacted]
Florida Health Justice Project
[redacted]
[redacted]

[redacted]

There were two other public comments received regarding the CHIP Waiver, see screenshots below.



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Children's Health Insurance Program Eligibility Extension Request"

SJ

Shavon J [redacted]

To FLMedicaidWaivers

Reply | Reply All | Forwar

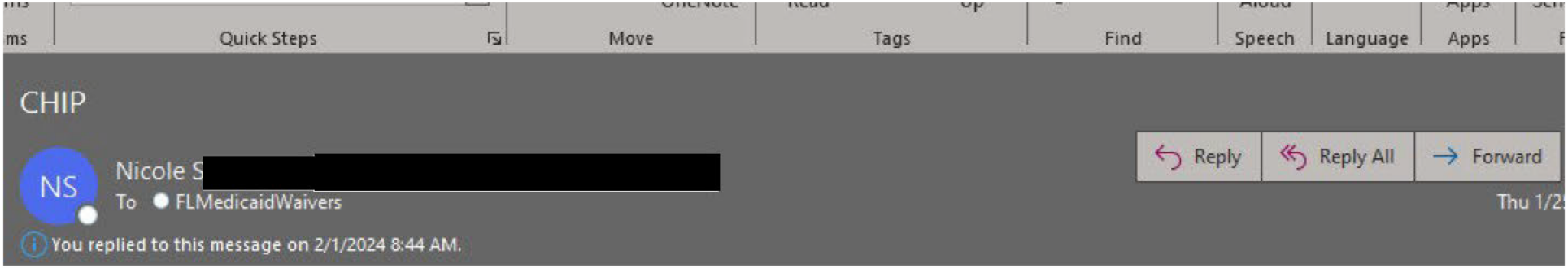
Tue

You replied to this message on 2/1/2024 8:46 AM.

To Whom It May Concern,

As a single mother that has worked extremely hard to provide my kids a better lifestyle I often fall in a gray area where I make too much money to qualify for a however I don't make enough to provide my daughter with disabilities valuable services that could help improve her life. Increasing the income could drastical lives of children in households where parents are working to provide a quality lifestyle and simultaneously being punished for doing so. The healthcare system broken in the United States often leaving many working class families without necessary services for their children with disabilities even though their hardwor fund many programs like this. It's imperative that we revisit program policies and adjust to keep up with inflation and societies changing needs. No family in A have to choose between valuable healthcare services and paying the light bill. I urge you to pass this bill and increase the income guidelines to afford many wo citizens access to affordable and quality healthcare.

Thank you!



We are an ABA provider. Will this result in a separate/ different credentialing / contracting for us as such? Thank you for your time in reply

Nicole S

SR Plus Behavior Consultants, Inc

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[redacted]

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[redacted]

Sent: Wednesday, February 14, 2024 2:23 PM

[redacted]

Subject: CHIP Waiver

Hi [redacted]

Can you confirm if there have been any additional comments on the CHIP Waiver, aside from those from Lynn H[redacted]?

Thank you!

[redacted]

[redacted]

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[redacted]

[redacted]

[redacted]

[redacted]

From: Ashley L[redacted]
Sent: Wednesday, February 21, 2024 1:58 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: Children's Health Insurance Program Eligibility Extension Request

Hello,

Please accept the attached comments on Florida's CHIP Extension Request.

Sincerely,
Ashley L[redacted]

Ashley L[redacted]
[redacted]
American Lung Association

Get Outlook for iOS

February 21, 2024

Jason Weida, J.D.
Secretary of Health Care Administration
Agency for Health Care Administration
2727 Mahan Drive, MS #20
Tallahassee, FL 32308

Re: Florida Children's Health Insurance Program Eligibility Extension

Dear Secretary Weida:

Thank you for the opportunity to submit state comments on the Florida Children's Health Insurance Program Eligibility Extension.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the state to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Florida's Medicaid program provides quality and affordable healthcare coverage. We support the state's proposal to expand the Children's Health Insurance Program (CHIP) coverage to 300% of the Federal Poverty Level (FPL). The state estimates that this demonstration will cover an additional 14,000 children in the first year of implementation, rising to 41,000 children in the fifth year.[1] Our organizations support this expansion of health coverage, particularly at a time when thousands of children and families in Florida have lost their healthcare coverage for procedural or paperwork issues.[2]

However, we remain concerned by the state's continued premium requirements. Our organizations have consistently supported the need for access to quality, affordable coverage.[3] The evidence is clear that premiums make it harder for individuals to obtain or keep healthcare coverage.[4] The inclusion of premiums can also exacerbate existing disparities in access to healthcare, as they have been shown to lead to lower enrollments for Black enrollees and lower-income enrollees, compared to their white and higher-income counterparts, respectively.[5] Premiums can be a significant barrier for individuals accessing care, and removing them increases equitable access to care for all enrollees.

Additionally, our organizations support continuous eligibility as a method to protect patients and families from gaps in care. Continuous eligibility promotes health equity,[6] and increases continuity of coverage. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[7] Our organizations support continuous eligibility in order to reduce these negative health outcomes for children in Florida, who face one of the highest uninsurance rates in the country.[8]

Our organizations support Florida's proposal to expand CHIP coverage to 300% of the FPL, and we urge the state to remove premium requirements to comply with the Consolidated Appropriations Act guidance, ensuring that children do not have gaps in coverage.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Diabetes Association
American Lung Association
Arthritis Foundation
Cancer*Care*
Child Neurology Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Muscular Dystrophy Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Pulmonary Hypertension Association
The AIDS Institute
The Leukemia & Lymphoma Society
WomenHeart

[1] "Children's Health Insurance Program Eligibility Extension." Florida Agency for Health Care Administration. January 23, 2024. Available at: https://ahca.myflorida.com/content/download/23900/file/Children%27s%20Health%20Insurance%20Program%20Eligibility%20Extension%20Request.pdf

[2] Letter from Xavier Becerra to Governor DeSantis. Department of Health and Human Services. December 18, 2023. Available at: https://www.hhs.gov/sites/default/files/sec-becerras-letter-to-fl-governor.pdf

[3] Consensus Healthcare Reform Principles. Partnership to Protect Coverage, 2024. Available at: https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles

[4] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[5] University of Wisconsin-Madison Institute for Research on Poverty. (2019). Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Available at https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf

[6] Chomilo, Nathan. Building Racial Equity into the Walls of Minnesota Medicaid. Minnesota Department of Human Services. February 2022. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209A-ENG

[7] Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[8] Florida, Children's Health Care Report Card. Center for Children and Families, McCourt School of Public Policy at Georgetown University. 2024. Available at: https://kidshealthcarereport.ccf.georgetown.edu/states/florida/

Children's Health Insurance Program Eligibility Extension

Section 1115 Title XXI Research Demonstration

New 5-Year Demonstration Request

Florida Agency for Health Care Administration

Contents

Program Application Overview

The Florida Agency for Health Care Administration (AHCA) is seeking federal authority from the Centers for Medicare & Medicaid Services (CMS) to implement a new section 1115 (Title XXI) Children's Health Insurance Program (CHIP) demonstration that offers program eligibility to children with family income above 200 percent of the federal poverty level (FPL)[1], up to 300 percent of the FPL, with enrollment subject to monthly premiums. This section 1115 demonstration will operate concurrently with the CHIP state plan which offers health insurance for uninsured children in families with incomes up to 200 percent of the FPL. The state is requesting authority for new premium amounts through this demonstration for all CHIP eligible recipients included in both the CHIP state plan and the section 1115 waiver authorities with incomes between 133 and 300 percent of the FPL. The State is seeking a proposed effective date of April 2024.

I. Demonstration Purpose, Goals, and Objectives and CHIP Program Overview

Demonstration Purpose, Goals, and Objectives

Florida is focused on ensuring that families have Pathways to Prosperity, which are individualized paths to prosperity, economic self-sufficiency, and hope through community collaboration between government entities, the private sector, community organizations, and the nonprofit sector. The Florida Legislature and Governor DeSantis recognized that parents who are working hard to improve their economic situation of their family could potentially lose access to subsidized CHIP health insurance for their children through even a small increase in their income, and that the potential loss of the subsidized coverage could be a disincentive to the parent in their pathway to prosperity and economic self-sufficiency. For example, a parent who worked more hours or received a promotion that increased annual income by $300 (approximately 1% of the FPL for a family of four with two children) would face an increase in premiums from subsidized CHIP coverage (with premiums of $240 per year per family) to $5,748 annually if they chose to participate in Florida's full-pay program.

In response, the Florida Legislature passed House Bill 121 (HB 121), signed into law in June 2023, to increase eligibility for the CHIP-subsidized KidCare programs above the current state plan threshold of 200 percent of the FPL up to 300 percent of the FPL. HB 121 also requires the State to establish new monthly premiums for CHIP enrollees. The new premium structure creates a graduated level of premiums that allows families with growing income to be able to continue to afford health insurance for their children.

This proposed demonstration is critical at this time as Florida's economy thrives, and more families are reporting increased income levels above those allowed for Florida Medicaid eligibility.

Florida's Medicaid redetermination process is already projected to increase enrollment in Florida's KidCare Full-Pay program, as current Medicaid enrollees with income levels too

[1] 200 percent represents the percent of the FPL prior to the application of the modified adjusted gross income (MAGI) conversion.

high for Medicaid and too high for CHIP-subsidized KidCare disenroll and look for other coverage options. Florida estimates 16,328 children with household incomes under 300% FPL will enroll in Full-Pay KidCare in Fiscal Year 2023-2024.

This proposed demonstration is expected to enable Florida to continue to make strides in increasing access to creditable health insurance coverage for lower-income children within the State while supporting increased economic self-sufficiency and pathways to prosperity. Accordingly, the goals and objectives of this demonstration are to:

- Increase enrollment and access to CHIP-subsidized coverage; and,

- Improve or maintain the rate of uninsured children under age 19 in the State of Florida.

CHIP Background

The Florida KidCare Program (KidCare or Program) was created by the Florida Legislature in 1998 in response to the passage of the federal Children's Health Insurance Program (CHIP) in 1997. The federal CHIP provides funding for states who choose to subsidize health insurance coverage to uninsured children in families with incomes that are too high to qualify for Medicaid but who meet other eligibility requirements. Florida's KidCare program encompasses four partner programs, that together with the availability of full-pay options for those who do not qualify for subsidized coverage matched by the federal government, offers coverage for all children in the State of Florida. The four programs that comprise Florida KidCare are:

1. **Medicaid for children** – Title XIX medical coverage to eligible children up to 1-year-old with family income that does not exceed 200 percent of the FPL and to eligible children, ages 1-18, with family income that does not exceed 133 percent of the FPL.

2. **MediKids Program** – MediKids provides low-cost health insurance for children ages 1 through 4. The MediKids program is similar to Medicaid. Children enrolled in the MediKids program receive medical services and benefits from Medicaid providers through Medicaid's Managed Medical Assistance (MMA) program. The program charges monthly premiums but does not impose any other form of beneficiary cost-sharing (i.e., no deductibles, co-payments, or coinsurance).

3. **Children's Medical Services (CMS)** – CMS is a collection of programs that provides a statewide managed care system for children (under age 19) with special health care needs and provides essential preventive, evaluative, and early intervention services for at-risk children.

4. **Florida Healthy Kids Program** – Florida Healthy Kids offers quality, affordable, child-centered health and dental insurance for children ages 5 through 18. Florida Healthy Kids has a subsidized plan for families who exceed the income eligibility

threshold for Medicaid, as well as full-pay options for those who do not qualify for subsidized coverage.

KidCare is governed by part II of Chapter 409, Florida Statutes (F.S.) and is administered jointly by AHCA, the Department of Children and Families, the Department of Health, and the Florida Healthy Kids Corporation (Corporation) established in Chapter 624, F.S. Table 1 below delineates the roles of each agency and the Corporation:

Table 1: Florida KidCare Organizational Structure

State Agency and Program(s)	Responsibilities
Agency for Health Care Administration (AHCA) (MediKids)	• Administers the Medicaid program (Title XIX) • Administers the MediKids program (Title XXI, ages 1-4) • Serves as lead Title XXI contact with the federal Centers for Medicare and Medicaid Services • Distributes federal funds for Title XXI programs • Manages the Florida Healthy Kids Corporation contract • Develops and maintains the Title XXI Florida KidCare State Plan
Department of Children and Families (DCF) (Medicaid for Children)	• Determines Medicaid (Title XIX) eligibility • Administers the CMS Behavioral Health Network (Title XXI, ages 0-18)
Department of Health (Children's Medical Services)	• Administers Children's Medical Services (Titles XIX and XXI, ages 0-18 with special health care needs)
Florida Healthy Kids Corp. (Healthy Kids)	• Performs administrative functions for Florida KidCare (eligibility determination, premium collection, marketing, and customer service) • Administers Florida Healthy Kids program (Title XXI, ages 5-18)

II. Demonstration Benefits, Eligibility and Cost-Sharing

Benefits

Florida KidCare health and dental services are delivered through quality plans that offer a choice of local doctors, dentists, specialists, hospitals, pharmacies, and other health care providers. Florida KidCare benefits minimally include but are not limited to: doctor visits, surgeries, check-ups, immunizations, dental and vision care, prescriptions, hospital stays, behavioral health, and emergencies.

Eligibility

Eligibility for Florida KidCare, including Florida Healthy Kids, is determined in part by age and household income, as a percent of the FPL, as indicated in Table 2 below:

Table 2 – Florida KidCare Eligibility and Cost-sharing Structure

Program	Ages	Family Income Eligibility			Existing Monthly Premium Structure	Copay (some services)
		FPL Threshold (Pre MAGI)	FPL Threshold (Post MAGI)	Annual Income[2]		
Medicaid for Children	0-1	185-200% FPL	194-210% FPL	$55,000 – $60,000	$0	$0
MediKids	1-4	133-200% FPL	140-210% FPL	$41,400 – $60,000	$15 for 133-158% FPL $20 for 158-200% FPL (per household)	Up to $10
Healthy Kids	5	133-200% FPL	140-210% FPL	$41,400 – $60,000		Up to $10
	6-18	100-200% FPL	112-210% FPL	$30,000 – $60,000		Up to $10
Children's Medical Services	0-18	Up to 200% FPL	Up to 210% FPL	$0 – $60,000		$0
Full-Pay (MediKids & Healthy Kids)	1-18	Over 200% FPL	Over 210% FPL	Over $60,000	$210 - MediKids $259 - Healthy Kids (per child)	$10 or $15

The demonstration will not change CHIP state plan eligibility for uninsured children in households with income up to the threshold of 200 percent of the FPL. The CHIP state plan will continue to be the basis of eligibility for uninsured children up to and including 200 percent of the FPL.

The demonstration will be the basis of coverage for uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL. The demonstration will also be the basis of authority for the monthly premium structure that will be applied to CHIP enrollees in households with income over 133 percent of the FPL up to the new coverage threshold of 300 percent of the FPL. See Table 3 below for the proposed new monthly premium structure for the Florida KidCare program.

Cost-sharing – Monthly Premium Structure

Families contribute monthly premiums to the cost of the Florida KidCare program based on their household size, income, and other eligibility factors. The premium does not vary by the number of children in the household. In accordance with HB 121, Florida is proposing to establish new premium tiers for CHIP enrollees above 133 percent of the FPL, including the new income coverage band from above 200 percent of the FPL up to 300 percent of the FPL. The new monthly premium structure proposed for the Florida KidCare program is as follows:

[2] Annual income based on 2023 federal poverty guidelines for a family size of 4 utilizing Pre-MAGI percentages

Table 3 – Proposed New Monthly Premiums for Households[3]

Proposed Premium Tiers by Federal Poverty Level					
Tier 1 FPL Range	Tier 2 FPL Range	Tier 3 FPL Range	Tier 4 FPL Range	Tier 5 FPL Range	Tier 6 FPL Range
133-175%	175-200%	200-225%	225-250%	250-275%	275-300%
$17	$30	$60	$95	$145	$195

III. Health Care Delivery System

Florida utilizes a managed care delivery system for all children enrolled in CHIP. Children in MediKids are enrolled in a Statewide Medicaid Managed Care program, Managed Medical Assistance plan. Children in Florida Healthy Kids are enrolled in one of three managed care plans contracted with the Florida Healthy Kids Corporation. Children in Children's Medical Services are enrolled in the Florida Department of Health's CMS plan. All plans are fully capitated plans that provide a comprehensive array of benefits to enrolled children.

IV. Enrollment & Expenditures

Projected Enrollment

The state's projected enrollment of uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL is listed in Table 4.

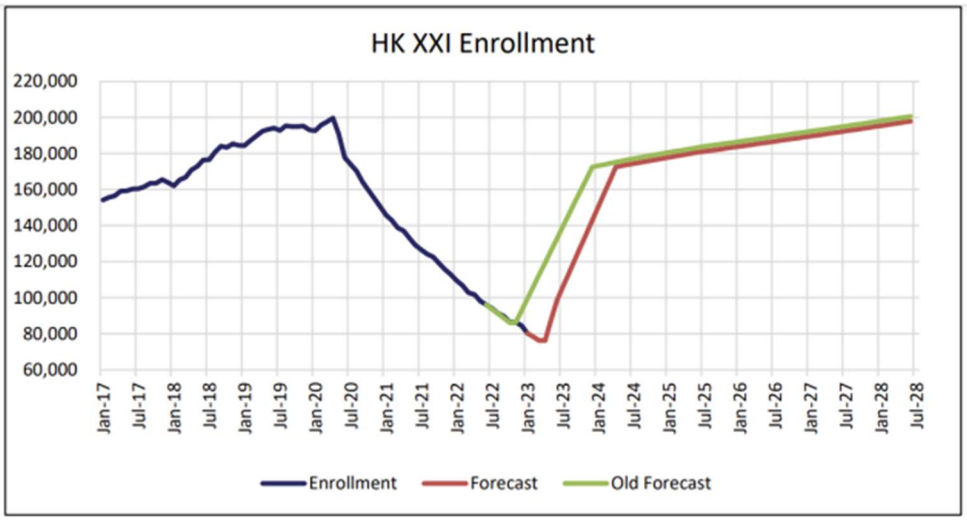
Table 4 – Projected Enrollment

DY01	DY02	DY03	DY04	DY05
14,649	28,926	38,360	41,272	41,874

Enrollment Impact

As of January 2023, 117,092 children are enrolled in KidCare. The State's 2023-2024 fiscal year projections assume that Medicaid redeterminations, which began in April 2023, will cause a 76.54% caseload growth in the CHIP Florida Healthy Kids portion of the KidCare program over the next year, as indicated by the graph below.

[3] Premiums will increase by three percent each year.



Florida's current work to complete Medicaid redeterminations in the post public health emergency return to normal operations per CMS guidance, has resulted in an estimated 16,328 children in Fiscal Year 2023-2024 with household income under 300% FPL who would only be eligible for enrollment in Full-Pay KidCare at an approximate annual premium of $3,114 plus nominal co-pays for certain services. The proposed demonstration will increase the upper eligibility band for KidCare eligibility, thereby making many Full-Pay KidCare enrollees now eligible for (more affordable) subsidized-KidCare coverage. Accordingly, the proposed demonstration is expected to impact projected overall CHIP enrollment by increasing the number of lower-income uninsured children eligible for enrollment in KidCare by approximately 165,000 children over the initial five years of implementation.

This new premium structure is not expected to impact general disenrollment trends or processes. Total projected enrollment in KidCare, including disenrollments due to failure to pay the monthly premium, was utilized to calculate the total costs for the demonstration.

Projected Expenditures

The state's projected medical assistance expenditures for coverage of uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL is listed in Table 5.

Table 5 – Projected Title XXI (CHIP) Expenditures

DY01	DY02	DY03	DY04	DY05
$16,999,053	$69,794,099	$106,984,015	$125,152,604	$135,457,940

The title XXI CHIP allotment neutrality analysis workbook for this 5-year request is provided as a separate attachment to this application.

V. Evaluation Parameters

The State, in consultation with a to-be selected evaluator, will identify validated performance measures that will assess the impact of the demonstration on CHIP enrollees. In addition, the State intends to work with the selected evaluator to identify meaningful comparison groups in designing the evaluation plan. It is the intent of the State to follow all CMS evaluation design guidance in working with the State's selected evaluator to draft an evaluation plan. See the proposed evaluation parameters in Table 5 below.

Table 5 – Proposed Evaluation Parameters

Proposed Hypothesis	Anticipated Measure(s)	Proposed Data Sources
The demonstration will increase enrollment and access to CHIP coverage.	Number of children with family income over 200% of FPL up to 300% of FPL enrolled in CHIP.	Florida CHIP claims and enrollment records
The demonstration will improve or maintain the rate of uninsured children under age 19 in the State of Florida.	Reported uninsurance rates: Number of children up to age 19 in Florida without health coverage	U.S. Census Bureau Data, American Community Survey (ACS)

VI. Waiver and Expenditure Authorities

Table 6 – Proposed Waiver and Expenditure Authorities

Section 1115(a)(1) Waiver Authorities	*Florda does not anticipate needing any waivers of the provisions under Title XXI of the Social Security Act to implement this demonstration.*
Section 1115(a)(2) Expenditure Authorities	Expenditure authority to offer CHIP coverage (through Florida KidCare) to uninsured children in households with income above 200 percent of the FPL up to 300 percent of the FPL.
	Expenditure authority to implement a monthly premium structure to be imposed on CHIP enrollees with income above 133 percent of the FPL up to 300 percent of the FPL as a condition of enrollment.

VII. Documentation of State Public Notice Process

The abbreviated notice was published on January 23, 2024 via Florida Administrative Register. Notice for tribal consultation was sent on January 23, 2024 to the Miccosukee and Seminole Tribes via email. As outlined in these public notices, AHCA is providing a minimum 30-day public comment period from January 23, 2024 at 3:00 pm EST, through February 21, 2024 at 3:00 pm EST. The draft section 1115 demonstration application and related public notice materials are posted for the minimum 30-day public comment period starting January 23, 2024 at 3:00 pm EST, on the Federal Waivers Home page located on the AHCA website: https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers.

The rest of this application section will be completed in the final submission to CMS after the State completes the full state public notice process in alignment with CMS requirements. In addition to publishing notices, AHCA will conduct two public hearings on the proposed application as outlined in the State's published public notices as well as on AHCA's website. AHCA will also collect and analyze all public comments received during the 30-day comment period into a report summary reflecting common trends and themes for inclusion in the final submission to CMS.

CONSENSUS HEALTHCARE REFORM PRINCIPLES

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all. This is particularly important for populations that have been marginalized or underserved based on their race, ethnicity, geography, gender identity, sexual orientation, disability status, country of origin, and socioeconomic status.

In addition, any reform measure must support a health care system that addresses persisting inequities, provides affordable, accessible and adequate health care coverage to all, and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

1: Health Insurance Must be Affordable

Affordable plans ensure patients have equitable access to needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for people with low incomes and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

2: Health Insurance Must be Accessible

All people, regardless of socioeconomic status, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

3: Health Insurance Must be Adequate and Understandable

All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer in a culturally competent manner prior to purchasing the plan.

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The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings

Samantha Artiga (https://www.kff.org/person/samantha-artiga/), **Petry Ubri, and Julia Zur**

Published: Jun 01, 2017

ISSUE BRIEF

Key Findings

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. This brief reviews research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. This research has primarily focused on how premiums and cost sharing affect coverage and access to and use of care; some studies also have examined effects on safety net providers and state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts. Together, the research finds:

- **Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.** These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty. Some individuals losing Medicaid or CHIP coverage move to other coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.
- **Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.** Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.
- **State savings from premiums and cost sharing in Medicaid and CHIP are limited.** Research shows that potential revenue gains from premiums and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses. Studies also show that raising premiums and cost sharing in Medicaid and CHIP increases pressures on safety net providers, such as community health centers and hospitals.

Introduction

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. Proponents of increasing premiums and cost sharing in Medicaid indicate that doing so will promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions.[1] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-1)

This brief, which updates an earlier brief "*Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/)," reviews research on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. It draws on findings from 65 papers published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations. This research has primarily focused on how premiums and cost sharing affect coverage and access to care; some studies also have examined effects on state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts.

Premiums and Cost Sharing in Medicaid and CHIP Today

Currently, states have options to charge premiums and cost sharing in Medicaid and CHIP that vary by income and eligibility group (Box 1). Reflecting these options, premiums and cost sharing in Medicaid and CHIP vary across states and groups. As of January 2017, 30 states charge premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or CHIP.[2] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-2) Most of these charges are limited to children in CHIP since the program covers children with higher family incomes than Medicaid and has different premium and cost sharing rules. States generally do not charge premiums for parents in Medicaid, but 39 states charge cost sharing for parents and 23 of the 32 states that implemented the Affordable Care Act (ACA) Medicaid expansion to low-income adults charge cost sharing for expansion adults.[3] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-3) Six states have waivers to charge premiums or monthly contributions for adults that are not otherwise allowed.[4] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-4)

Box 1: Medicaid and CHIP Premium and Cost Sharing Rules

Medicaid

- States may charge premiums for enrollees with incomes above 150% of the federal poverty level (FPL), including children and adults. Enrollees with incomes below 150% FPL may not be charged premiums.
- States may charge cost sharing up to maximums that vary by income (Table 1). States cannot charge cost sharing for emergency, family planning, pregnancy-related services, preventive services for children, or preventive services defined as essential health benefits in Alternative Benefit Plans in Medicaid. In addition, states generally cannot charge cost sharing to children enrolled through mandatory eligibility categories. The minimum eligibility standard for children is 133% FPL, although some states have higher minimums.
- Overall, premium and cost sharing amounts for family members enrolled in Medicaid may not exceed 5% of household income. This 5% cap is applied on a monthly or quarterly basis.

CHIP

- States have somewhat greater flexibility to charge premiums and cost sharing for children in CHIP, although there are limits on the amounts that states can charge, including an overall cap of 5% of household income.

Table 1: Maximum Allowable Cost Sharing Amounts in Medicaid by Income

	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of state cost	20% of state cost
Non-Emergency use of ER	$8	$8	No limit (subject to overall 5% of household income limit)
Prescription Drugs			
Preferred	$4	$4	$4
Non-Preferred	$8	$8	20% of state cost
Inpatient Services	$75 per stay	10% of state cost	20% of state cost

Notes: Some groups and services are exempt from cost sharing, including children enrolled in Medicaid through mandatory eligibility pathways, emergency services, family planning services, pregnancy related services, and preventive services for children. Maximum allowable amounts are as of FY2014. Beginning October 1, 2015, maximum allowable amounts increase annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

Effects of Premiums (Table 1 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-1/))

A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals. Studies show that premiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults.[5] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-5),[6] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-6),[7] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-7),[8] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-8),[9] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-9),[10] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-10) Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid and CHIP.[11] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-11),[12] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-12),[13] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-13),[14] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-14),[15] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-15),[16] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-16),[17] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-17),[18] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-18),[19] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-

findings/view/footnotes/#footnote-220856-19)[20] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-20)[21] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-21)[22] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-22)[23] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-23)[24] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-24)[25] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-25)[26] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-26)[27] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-27)[28] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-28)[29] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-29)[30] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-30)[31] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-31)[32] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-32)[33] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-33)[34] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-34)[35] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-35)[36] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-36)[37] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-37)[38] (https://www.kff.org/medicaid/issue-brief/the-effects-of-

premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-38)’[39](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-39)

Although some individuals who disenroll from Medicaid or CHIP following premium increases move to other sources of coverage, others become uninsured and face negative effects on their access to care and financial security. Those with lower incomes and those without a worker in the family are more likely to become uninsured compared to those with relatively higher incomes or with a worker in the family, reflecting less availability of employer coverage.[40](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-40)’[41](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-41)’[42](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-42)’[43](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-43)’[44](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-44)’[45](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-45)’[46](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-46)’[47](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-47)’[48](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-48)’[49](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-49) Studies also show that those who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens.[50](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-50)’[51](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-51)’[52](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-52) ’[53](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-53),[54] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-54) Several studies suggest that these negative effects on health care are largest among individuals with greater health care needs.[55] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-55),[56] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-56)

Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty. Given that most states limit premium charges to children in CHIP, most studies of premium effects have focused on children in CHIP, who generally have incomes above 100% or 150% of the federal poverty level. A range of these studies show that premium effects are larger among children at the lower end of this income range, who have greater disenrollment and increased likelihood of becoming uninsured.[57] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-57),[58] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-58),[59] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-59),[60] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-60),[61] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-61),[62] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-62),[63] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-63),[64] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-64),[65] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-65) Reflecting the more limited use of premiums among Medicaid enrollees with incomes below poverty, fewer studies have focused on this population. However, studies that have focused on poor Medicaid enrollees found substantial negative effects on enrollment from premiums.[66] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-66),[67] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-67),[68] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-68),[69] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-69) For example, in Oregon, nearly half of adults disenrolled from Medicaid after a premium increase with a maximum premium amount of $20, with many becoming uninsured and facing barriers to accessing care, unmet health needs, and increased financial burdens.[70] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-70),[71] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-71),[72] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-72) Similarly, a more recent study of the Healthy Indiana Plan waiver program for Medicaid expansion adults with incomes below 138% FPL, which requires premiums that range from $1-$100 to enroll in a more comprehensive plan, found that 55% of eligible individuals either did not make their initial payment or missed a payment.[73] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-73) Research also finds that premium effects may vary by other factors beyond income. For example, one study finds larger effects of premiums among families without an offer of employer-sponsored coverage.[74] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-74) Some research also suggests that increases in Medicaid and CHIP premiums may have larger effects on coverage for children of color and among children whose families have lower levels of educational attainment.[75] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-75),[76] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-76),[77] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-77)

Research finds varying implications of premiums for individuals with significant health needs. Overall, individuals with greater health needs are less likely to disenroll from Medicaid or CHIP coverage and are more likely to have longer periods of Medicaid or CHIP coverage compared to those with fewer health needs.[78] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-78),[79] (https://www.kff.org/medicaid/issue-brief/the-effects-of-

premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-79)',[80] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-80)',[81] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-81) However, findings vary regarding how individuals with health needs respond to premium increases. Some studies show that individuals with greater health needs are less sensitive to premium increases compared to those with fewer health needs, reflecting their increased need for services.[82] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-82)',[83] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-83) These findings suggest that individuals with greater health needs are more likely than those with less significant health needs to remain enrolled following premium increases, but then face increased financial burdens to maintain their coverage. Other studies find that children with increased health needs are as likely or more likely than those with fewer health needs to disenroll from coverage following premium increases, suggesting premiums may lead to children going without coverage despite ongoing health needs.[84] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-84)',[85] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-85)

Effects of Cost Sharing (Table 2 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/))

A wide range of studies find that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services. The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, shows a reduction in use of services after cost sharing increased, regardless of income.[86] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-86) Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services,[87] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-87) including vaccinations,[88] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-88) prescription drugs,[89] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-

on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-89),[90] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-90),[91] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-91),[92] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-92) mental health visits,[93] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-93) preventive and primary care,[94] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-94),[95] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-95),[96] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-96),[97] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-97),[98] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-98) and inpatient and outpatient care,[99] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-99),[100] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-100) and decreased adherence to medications.[101] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-101),[102] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-102),[103] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-103) In many of these studies, copayment increases as small as $1-$5 can effect use of care. Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals.[104] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-104),[105] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-105) Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room.[106] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-

on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-106) Two studies have found that copayments do not negatively affect utilization.[107] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-107),[108] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-108) In one case, the authors suggest that increases in provider reimbursement may have negated effects of the copayment increases, particularly if not all copayments were being collected by providers at the point of care.[109] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-109)

Research points to varying effects of cost sharing for people with significant health needs. Some studies find that utilization among individuals with chronic conditions or significant health needs is less sensitive to copayments compared to those with fewer health needs. As such, these individuals face increased cost burdens associated with accessing care because of copayment increases.[110] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-110),[111] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-111) Other research finds that even relatively small copayments can reduce utilization among individuals with significant health needs.[112] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-112),[113] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-113),[114] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-114)

Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families.[115] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-115),[116] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-116),[117] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-117),[118] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-118),[119] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-119),[120] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-120),[121] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-121),[122] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-122) For example, studies have found that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia[123] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-123) and reduced treatment for children with asthma.[124] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-124) Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small copayments can add up quickly when an individual needs ongoing care or multiple medications.[125] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-125),[126] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-126)

Findings on how cost sharing affects non-emergent use of the emergency room are limited. One study found that these copayments reduce non-urgent visits.[127] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-127) Other studies find that these copayments do not affect use of the emergency room.[128] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-128),[129] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-129)

Effects on State Budgets and Providers (Table 3 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-3/))

Research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited. Studies find that potential increases in revenue from premium and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured

individuals; and administrative expenses.[130](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-130),[131](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-131),[132](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-132),[133](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-133),[134](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-134),[135](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-135),[136](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-136) One state study found increased revenues from premiums without significant effects on enrollment, but authors note a range of program-specific factors that may have contributed to this finding, including it being limited to a Medicaid-buy in program for individuals with disabilities with incomes above 150% FPL who may be less price-sensitive to the increase and the state implementing administrative processes designed to minimize disenrollment.[137](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-137)

Studies also show that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety net providers, such as community health centers and hospitals. Several studies show that coverage losses following premium increases lead to increases in the share of uninsured patients seen by providers[138](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-138),[139](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-139),[140](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-140) and increased emergency department use by uninsured individuals.[141](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-141),[142](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-142) One study also found that increases in copayments led to community health centers having to divert resources for medications for uninsured

individuals to help people who could not afford copayments and that copayments increased the rate of “no shows” for appointments at community health centers.[143] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-143)

Conclusion

Recently, there has been increased interest at the federal and state levels to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. This review of a wide body of research provides insight into the potential effects of increasing premiums and cost sharing for Medicaid enrollees. It shows that premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and that even relatively small levels of cost sharing reduce utilization of services. As such, increases in premiums and cost sharing result in increased barriers to coverage and care, greater unmet health needs, and increased financial burdens for families. Further, the research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited and that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety-net providers.

STUDY TABLES (HTTPS://WWW.KFF.ORG/REPORT-SECTION/THE-EFFECTS-OF-PREMIUMS-AND-COST-SHARING-ON-LOW-INCOME-POPULATIONS-UPDATED-REVIEW-OF-RESEARCH-FINDINGS-STUDY-TABLES/) ›

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DEPARTMENT OF HUMAN SERVICES

Building Racial Equity into the Walls of Minnesota Medicaid

A focus on U.S.-born Black Minnesotans

February 2022

For accessible formats of this information or assistance with additional equal access to human services, write to BREWMedicaid.DHS@state.mn.us, call 651-431-5608, or use your preferred relay service. ADA1 (2-18)

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Contents

Executive summary

> "Of all the forms of inequality, injustice in health is the most shocking and the most inhuman."
>
> *– Dr. Martin Luther King, Jr.*

Racial health disparities result from centuries of policies that have structured opportunity along the lines of race in Minnesota. While several communities in the state have and continue to experience structural disadvantage, this report focuses primarily on U.S.-born Black Minnesotans. Black/African Americans account for 13% of Minnesota Medicaid enrollees vs. 7% of the general population. However, data shows that Medicaid has an even more significant impact on access to care for Black Minnesotans. Analysis of 2019 data by the University of Minnesota's State Health Access Data Assistance Center showed that approximately 44% of African American Minnesotans under the age of 65 rely on Medicaid for health care coverage. Medicaid coverage for African American Minnesotans is higher outside the seven-county metro area, and 64% of Black Minnesotan children receive access to health care through Medicaid.

In Minnesota, Black communities have been the target, either directly or indirectly, of many policies that structure what are now widely known to be the social determinants of health, referenced in this report as social drivers of health. University of Minnesota economist Dr. Samuel Myers coined the term "Minnesota paradox" to describe how Minnesota can have one of the highest qualities of life for white Minnesotans, while "African Americans are worse off in Minnesota than they are in virtually every other state in the nation" (Myers, 2020). These ongoing disparities reveal a system not broken but accomplishing what it was designed to do. Medicaid is a key component of that system in Minnesota.

A community-informed, iteratively developed report

This report aims to continue the evolution of how policy within the Minnesota Department of Human Services (DHS) is designed, proposed and considered by intentionally striving for community co-creation. Given the distinct current and historical contexts that have contributed to the health of Black communities in the United States, and in order to focus on specific community strengths and the opportunities to build racial equity from their perspective, this report focuses on U.S.-born Black communities. At the outset of drafting this report, staff met with individuals from the U.S.-born Black community, leaders of organizations that are a part of the community and those working to advance racial equity in health care for Black Minnesotans.

The report's team then aligned the input received from those initial meetings with community collaborators with policy areas within DHS. The team then met with specific DHS divisions involved in the creation and stewardship of those policy areas. Those conversations informed draft "Calls to Action" shared during two public Community Conversations. The team sought further guidance from community members through facilitated discussion at those sessions, and the reflections and recommendations from all of these conversations have been incorporated into this report.

What levers Medicaid has to address racial equity for U.S.-born Black Minnesotans

Eligibility and enrollment

- **Who is eligible for Medicaid? What is the process for enrollment? For re-enrollment? How does someone get and keep their Medicaid insurance in the first place?**

Access

- **Once someone has Medicaid, can they access the care they need? Do they have access to primary care? Dental or behavioral health services? Do they have access to culturally relevant care or care from a provider who shares their cultural background? Do they have transportation or interpreter services?**

Quality

- **If they have access to care, are they getting quality care? Do the metrics Medicaid uses to determine quality care meet the community's definition of quality care?**

Early opportunities

- **Medicaid disproportionately covers pregnant people and children. Knowing the long term impact of the first years of a child's life, how can Medicaid ensure health and racial equity from the very start?**

When looking at how Medicaid can build racial equity for U.S.-born Black Minnesotans into its policies, the report team decided to approach the work by considering four key "levers" of Medicaid policy development: Eligibility/enrollment, access, quality and early opportunities.

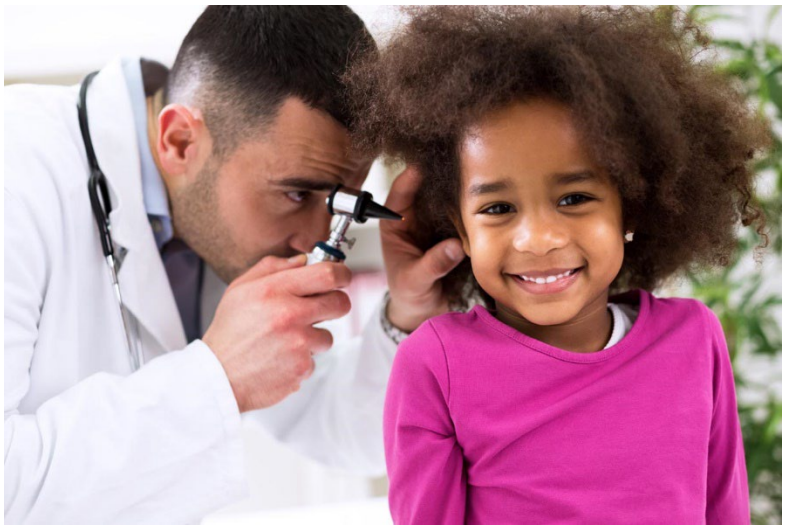
What Medicaid can do now to continue to address racial equity for U.S.-born Black Minnesotans?

This iterative process resulted in **Calls to Action** for three Medicaid policies and programs that were most commonly cited by the U.S.-born Black Minnesotan community members the report team engaged with: Enrollment and renewal, access to culturally relevant care and, community engagement and co-creation. Importantly, since Medicaid services cannot currently be granted solely on the basis of an individual's racial background, none of the Calls to Action seek to create

Medicaid-funded services that are racially exclusive. Instead, there is recognition of the long overdue need to ensure policies, programs and the administration of each are done with awareness and action toward racial equity. With that frame as a guide, focusing the agency's efforts on changes available to all and the communication of these changes to communities most impacted by structural racism, can notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

Call to Action: Simplify and support enrollment and renewal

1. Pursue continuous eligibility policies



Continuous eligibility allows Medicaid enrollees to maintain their enrollment regardless of changes in circumstances for up to 12 months at a time. The Social Security Act currently gives states the option to provide continuous eligibility to children under age 19 for a period of up to 12 months. **DHS should pursue the state plan option under the Social Security Act to provide continuous eligibility to children.** Given what is known about the importance of the first five years on early brain development, consistent access to health care, screenings and services is critical. The state also now has experience with decreasing enrollment churn during the past nearly two years of the COVID-19 pandemic. **DHS should therefore explore an 1115 Medicaid Demonstration Waiver to implement 72 months of continuous eligibility for children on Medicaid up to age 6 as well as establish 24-month continuous eligibility for all enrollees age 6 and older.**

2. Support navigators and simplify the enrollment and renewal process

Given the complexity of enrolling and renewing one's application, the fact that many people in poverty lack a home computer with internet access and that navigators live in communities, increasing the availability and utilization of navigators remains an important option to help people to apply. **DHS should work with navigators and the U.S.-born Black community to develop a plan focused on**

ensuring eligible Black Minnesotans gain and maintain Medicaid coverage throughout the year and in preparation for transitioning out of the federal public health emergency.

Call to Action: Increase investment in culturally relevant care for U.S.-born Black Minnesotans on Medicaid

1. Invest in an internal structure that has a specific focus on U.S.-born Black Minnesotans

Addressing generations of structural inequity will require sustained intention. A dedicated internal structure could provide a direct connection to U.S.-born Black Medicaid enrollees, community-based organizations and other institutions to inform and co-create policy and programs that elevate strengths and address inequities. A division focused on Black Medicaid enrollee health could also ensure that efforts throughout DHS and other state agencies (e.g., the Minnesota Department of Health) leverage all available funding sources to close the gaps seen in health outcomes.

2. Continue to prioritize and align standardization and disaggregation of race, ethnicity and language data

While an incomplete and imperfect proxy for culture, race, ethnicity and language data can serve as an important initial signal and help guide and inform conversation and collaboration with communities. One Community Conversation participant noted that there is a need to "proactively identify data — there's not enough data, and the way we collect data is not moving at the same speed as how diversity is increasing." Standardized and disaggregated race, ethnicity and language data will be important for identifying communities as well as holding accountable DHS, managed care organizations, counties, clinicians and others who serve Medicaid enrollees.

Call to Action: Fund community conversations with U.S.-born Black Minnesotans on Medicaid

Community members noted that the COVID-19 pandemic has clearly demonstrated the impact of a fractured trust between state agencies and the U.S.-born Black community. A repair of this trust requires relationships be built over years and gives community the opportunity to "start a journey of trusting larger agencies that provide resources and services." Therefore, **DHS should integrate not just community engagement in general but longitudinal, culturally specific engagement of enrollees and their families into its routine policy, budget and administrative activities.** Seeing community as true

partners and co-creators at all times, not just during a pandemic or to address a specific, research-identified gap, will go a long way to repairing the trust that has been broken.

Capturing the moment for change

While this report prioritizes some specific Medicaid policy solutions, there were other notable observations from our conversations. First, there is a clear sense of urgency from community and DHS staff alike. Second, DHS divisions seemed empowered by their ability to effect intrinsic change. Success feels within reach. There was widespread agreement that DHS could be doing much more around racial health disparities, and there were many ideas to bring forward to community for further conversation around solutions. A final and critical theme identified in these conversations is the shared concern that, as in the past, DHS' current focus on health disparities is again just another flash in the pan. Yet, despite the weariness, both the community and DHS staff shared a willingness to try again.

The Calls to Action detailed and justified in this report therefore not only serve as a guide to prioritize actions to improve racial equity for U.S.-born Black Minnesotans on Medicaid but also overlap with the needs of other historically under-resourced communities. The iterative process established in developing this report, its policy recommendations and the subsequent accountability for action set the expectation for other work within DHS. Next steps must include reports on building racial and health equity into Medicaid for Native and Indigenous Minnesotans, Hispanic/Latino Minnesotans, Asian-Pacific Islander Minnesotans, immigrants/new Minnesotans, Minnesotans who are LGBTQ+, Minnesotans living with disabilities, unhoused Minnesotans and incarcerated Minnesotans.

I. Introduction

"There has never been any period in American history where the health of blacks was equal to that of whites. Disparity is built into the system" (Evelynn Hammonds)

Harvard science historian Evelynn Hammonds' reflection on who our health care systems have (Interlandi, 2019) and have not, been designed to serve has become inescapable in the wake of COVID-19. A novel viral respiratory illness that spreads quickly by symptomatic and asymptomatic individuals, COVID-19 has been indiscriminate in its transmission. However, as noted in the early weeks of the pandemic by social and public health epidemiologists and clinicians with extensive experience in health inequity, COVID-19's "propagation within a society steeped in structural racism will undoubtedly … lead to disproportionate impacts among marginalized racial groups in this country" (Bailey et al., 2020).

Before and throughout the pandemic, Black and Latino Minnesotans have worked in industries identified as "essential services or businesses" at disproportionate rates. They earn lower wages, have less access to adequate health care and experience higher exposure to COVID-19 since they are unable to work from home. MDH data has consistently revealed that Black, Indigenous and Latino Minnesotans have had the highest age-adjusted rates of COVID-19 cases, hospitalizations, intensive care unit (ICU) admissions and deaths (MN Gov, 2021)

Racial disparities in Minnesota

- The state of Minnesota as a whole has the second biggest income inequality gap between Black and white people in the entire nation. Compared to white Minnesotans, Asian people earn 94 cents on the dollar, Black people earn 71 cents, Latino people earn 70 cents and Indigenous people earn 68 cents (Minnesota House of Representatives, 2020).
- Minnesota has one of the widest homeownership gaps in the nation. While 77 percent of white households own their home, 57 percent of Asian, 46 percent of Native American, 45 percent of Latino and just 24 percent of Black households own their home (Minnesota House of Representatives, 2020).
- In Minnesota, Indigenous students are ten times more likely to be expelled or suspended than their white peers. Black students are eight times more likely to be expelled or suspended than their white peers (Minnesota House of Representatives, 2020).
- Black and Latino Minnesotans have reported food insecurity at more than double the rate of white Minnesotans (Wilder Foundation, 2020).
- Black Minnesotans have been disproportionately affected by a loss of employment during the COVID-19 pandemic (MN Gov, 2021)
- Black, Indigenous and Latino Minnesotans have lower COVID-19 vaccination rates statewide (Minnesota Department of Health, 2021a) and among age-eligible Minnesota Medicaid enrollees (Infogram, 2021)
- Total mortality increased in 2020 by 14 percent for non-Hispanic White Minnesotans and 41 percent for BIPOC (Black, Indigenous, and people of color) Minnesotans (Wrigley-Field et al., 2021).

These disparities result from centuries of policies that have structured opportunity along the lines of race in Minnesota. While several communities in the state have and continue to experience structural disadvantage, this report will focus primarily on U.S.-born Black Minnesotans. As noted in DHS' 2020 report on deep poverty (DHS, 2020), "historical atrocities, such as slavery and the Jim Crow era in the case of African-Americans, have huge effects on families through the formation of identity, values, attitudes, beliefs, and parenting practices developed over generations (Lichtman, 1984; Evans-Campbell, 2008) as well as clinically observable intergenerational health effects in current generations (Yehuda & Lehrner, 2018)." The historical and ongoing trauma experienced by U.S.-born Black Minnesotans, and its resultant impact on health and on the relationship and trust between the community and the state, is distinct from other communities in Minnesota who also identify as Black and from other historically oppressed communities, such as Native Americans.

In Minnesota, Black communities have been the target, either directly or indirectly, of many policies that structure what are now widely known to be the social determinants of health, referenced in this report as social drivers of health. Examples include:

- What is your level of education?
- Are you housed? Do you have access to a car?
- How easy is it for you to get fresh fruits and vegetables?
- Are members of your community disproportionately incarcerated?
- Do you have ample opportunity for employment with a livable wage?
- Do you experience the stress of institutionalized racism and unconscious bias?
- Do you live in a safe community, far from industrial sources of pollution and high crime rates?

Though it has not always been intuitive, answers to these questions influence people's health — as much or more than access to a doctor's office or hospital. The consistent denial to the same opportunities for housing (Horowitz et al., 2021), education (Grunewald & Nath, 2019), nutrition (Wilder Foundation, 2020), healthy neighborhoods (Reconnect Rondo, 2020) and justice under the law (Beckett & Ajasa, 2021) makes the resultant health disparities experienced by Black Minnesotans less surprising. University of Minnesota economist Dr. Samuel Myers coined the term "Minnesota paradox" to describe how Minnesota can have one of the highest qualities of life for white Minnesotans, while "African Americans are worse off in Minnesota than they are in virtually every other state in the nation" (Myers, 2020). These ongoing disparities reveal a system not broken, but accomplishing what it was designed to do. As noted in the 2020 Minnesota House Select Committee on Racial Justice Report to the Legislature, "Understanding that racially discriminatory public policy decisions shaped these disparities, the Legislature will need to consider and implement racially conscious policy changes to overcome these disparities" (Minnesota House of Representatives, 2020). Medicaid in Minnesota is an important program to begin ensuring racial equity.

Medicaid and related programs like Minnesota Care provide essential health care to people across Minnesota. Roughly 1.3 million people were enrolled in 2021. Medicaid serves more than half a million children each year, covering almost one- third of all Minnesota children before the COVID-19 pandemic. Geographically, the percent of Minnesotans served by Medicaid in Greater Minnesota is the same or slightly higher than those served in the Twin Cities metro area (Fig 1).

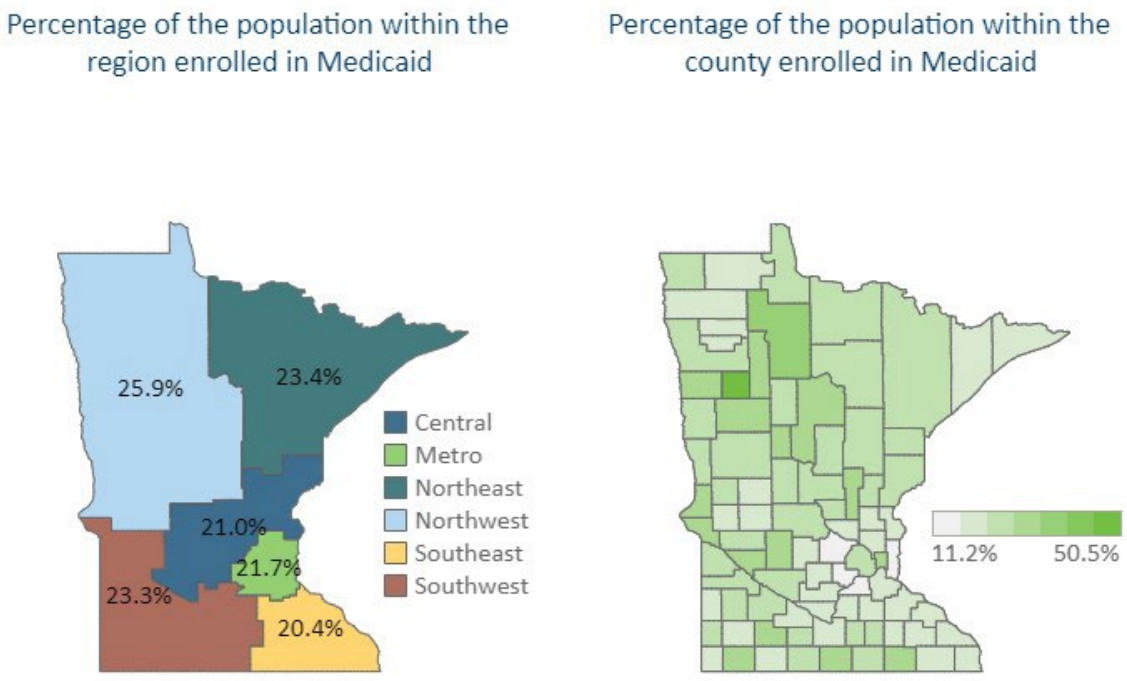


Fig 1. Percent of Minnesotans served by Medicaid based on geography, 2021

Enrollment data source: Minnesota Department of Human Services, December 2021. Population data source: U.S. Census Bureau, 2020. 2021 population estimates are not available yet. The denominator for the 2021 percentage enrolled by region and county is the 2020 population estimate.

These numbers are even more significant when examining the racial demographics of Minnesota's Medicaid program. Only about 73% of enrollees currently report their race and ethnicity upon enrollment in Minnesota's public health care programs, however racial demographic data provided to other public programs gives insight into around 93% of enrollees' identified race/ethnicity. From this, the data shows a disproportionate representation in Minnesota's Medicaid program among Black/African American people when compared to the general Minnesota population. Black/African American Minnesotans account for 18% of Medicaid enrollees vs. 7% of the general population (Fig 2).

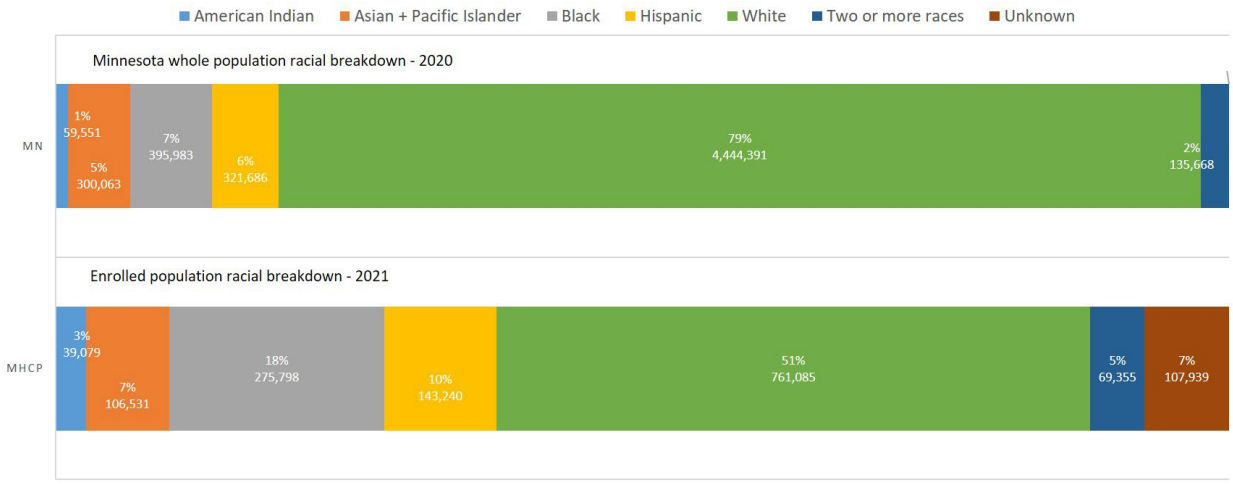


Fig 2. State of Minnesota demographics compared to Medicaid enrollee demographics, by race/ethnicity, 2021

Enrollment data source: Minnesota Department of Human Services, December 2021. Population data source: U.S. Census Bureau, 2020.

Data on how different racial/ethnic communities in Minnesota access care makes clear the significant impact Medicaid has on addressing racial health equity in the state. Data from a 2021 analysis of 2018-2019 data by the University of Minnesota's State Health Access Data Assistance Center (SHADAC) showed that approximately 41.5% of Black, 39% of Native American/Alaskan Native, 29.5% of Hispanic and 20.2% of Asian Minnesotans rely on Medicaid for health care coverage (Fig 3). Analysis of 2018-2019 data on Minnesotan children 0-18 years old who rely on Medicaid revealed that 64% of Black children, 59% of Native American/Alaskan Native children, 49% of Hispanic children, and 33% of Asian Minnesotan children rely on Medicaid, percentages that likely increased during the pandemic.

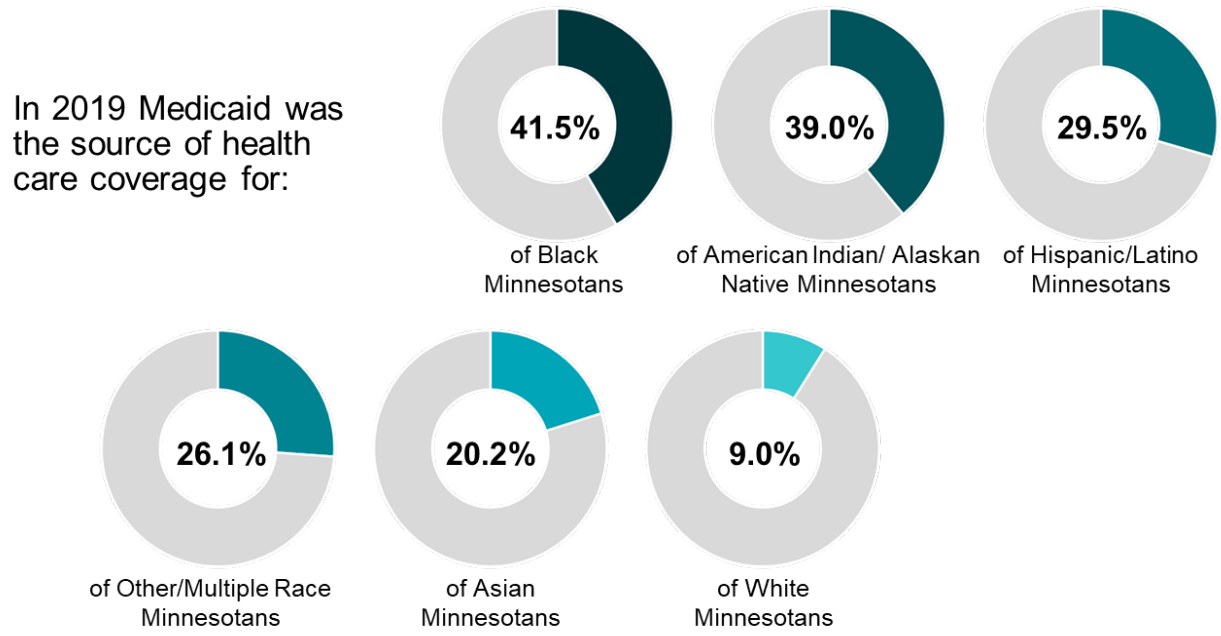


Fig 3. Percent of Minnesotans with Medicaid as source of coverage, by race, 2018-2019

Source: SHADAC analysis of the 2018-2019 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Note: Data years 2018 and 2019 were combined to increase the sample size and improve the reliability of estimates among Minnesotans by race and ethnicity.

COVID-19 exemplifies the need for the Department of Human Services to examine its policies and programs in the context of their historical, current and future health and racial equity impact. This examination cannot be performed in government's usual silos. Communities impacted the most by structural racism and inequity need to be engaged early and provided accountability, as Minnesota strives to dismantle systems of harm and build systems that support the health of all. This report aims to continue the evolution of how policy within DHS is designed, proposed and considered by intentionally striving for community co-creation at the level of "Involve" along the International Association for Public Participation's (IAP2) spectrum (Figure 4).

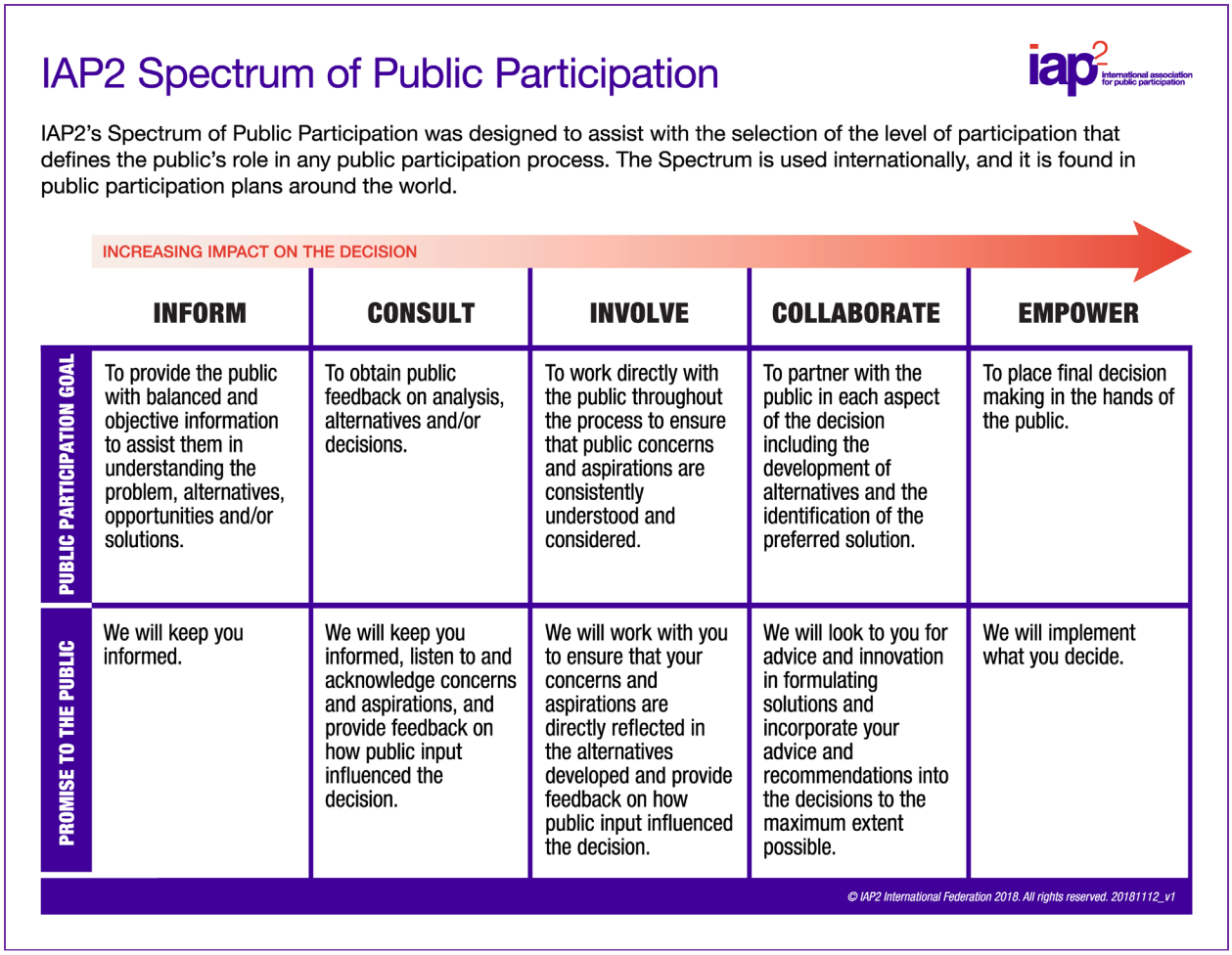


Fig 4. Spectrum of Public Participation. (c) International Association for Public Participation www.iap2.org.

To meet the level of "Involve," at the outset of this report staff met with individuals from the U.S.-born Black community and leaders of organizations that are a part of the community or working to advance racial equity in health care for Black Minnesotans. During these initial meetings, staff outlined four levers within Medicaid policy that could be used to continue to build racial equity for U.S.-born Black Minnesotans: Eligibility/Enrollment, Access, Quality and Early Opportunities.

Initial Community Contributors

- MDH Health Equity and Advisory Leadership (HEAL) Council
- DHS Cultural and Ethnic Communities Leadership Council
- Council for Minnesotans of African Heritage
- Voices for Racial Justice
- African American Leadership Forum
- Cultural Wellness Center
- Center for Economic Inclusion
- Former Minnesota State Senator Jeff Hayden

Community Conversation Participants

- Minnesota Health Care Program (Medicaid) enrollees
- Health Care Providers
- Community Based Organizations
- County Public Health and Human Service staff
- Managed Care Organization staff
- University of Minnesota School of Public Health and Medical School faculty
- Minnesota DHS and other State agency staff

Staff then took the input received from those initial meetings to relevant policy areas within DHS. Staff met with specific DHS divisions involved in the creation and stewardship of those policy areas. Those conversations further informed the initial "Calls to Action" drafted for this report. DHS then held two public Community Conversations to share the initial draft "Calls to Action" and sought further guidance from community members through facilitated discussion. Reflections and comments from all of these conversations have been incorporated into this report. The final report will also be purposefully shared back with community members upon release.

The hope is that through the path and guidance this report lays out, health and state policies continue to move toward a standard where the work is more fully informed by the communities that make up the state and that are served. And that work leads to rebuilding of trust with communities whose trust has been violated over generations. Ultimately, the state must realize its potential to offer all Minnesotans the same level of opportunity for health.

II. Why focus on racial equity

DHS' Equity Policy

DHS has worked for years on improving equity within the agency and in the experience of Minnesotans who rely on its services. In 2017, DHS institutionalized the agency's Equity Policy. This policy emphasizes the agency's commitment to "advancing equity, reducing disparities in DHS program outcomes, and improving access to human services for all communities experiencing inequities." This policy models the Minnesota Department of Health's Health in All Policies (HiAP) approach, with the goal of having a human-centered design framework that considers achieving health beyond just the absence of disease, instead realizing a complete state of physical, mental and social wellbeing. Recognizing that Minnesota's structural inequities cut across sectors, DHS' HiAP approach requires solutions that both focus within DHS and also cut across agency and public-private sector boundaries to address the broad factors that make up the drivers of health (Healthy People 2020). This policy requires that communities experiencing inequities be consulted when programs are designed, implemented and evaluated. The DHS Equity Policy compels all DHS employees to include considerations for equity impacts on decisions specific to service delivery and workforce, program and project design and implementation, strategic planning, and legislative proposals, among other focus areas.

The State Medicaid Agency within DHS administers the Medicaid program and has worked to operationalize the DHS Equity Policy since its inception. Following the policy as a guiding principle, the Medicaid Agency institutionalized racial equity mechanisms and tools (Government Alliance on Race and Equity, 2022) to include an equity lens in all areas of work. The design has a process improvement lens, in which progressive development of trainings, beta testing and implementation of tools is done at a granular level. The Medicaid Agency's approach considered business needs and employee feedback, keeping the diverse needs and backgrounds of enrollees at the fore. The Medicaid agency's equity committee developed a comprehensive set of racial equity tools that have enhanced the effectiveness of Medicaid programs, policies, decisions and administrative procedures.

Know the History

Consider historical events that have negatively impacted Black, Indigenous, and Communities of Color. Acknowledge them and create space for communities to share as to not repeat the same mistakes.

Develop the Proposal

What is the policy, program, practice, or budget decision under consideration? What are the desired results and outcomes?

Monitor Data

What is the data? What does the data tell us? Are they disaggregated by race?

Engage the community

How have communities been engaged? Are there opportunities to expand engagement?

Analysis and strategies

Who will benefit from or be burdened (intent vs. impact) by your proposal? What are your strategies for advancing racial equity or mitigating unintended consequences?

Implementation

What is your plan for implementation?

Accountability and Communication

How will you ensure accountability, communicate, and evaluate results?

The Medicaid agency's equity tools and mechanisms support the DHS Equity Policy's goal of eliminating inequity. When incorporating an equity assessment analysis and best practices into program, policy and procedure decisions:

- How the equity tool is implemented and used will differ from program to program, department to department and county to county. Accountability for implementation and use within the Medicaid agency and to respective communities is essential.
- Approach equity analyses from a continuous improvement perspective, as opposed to a checklist. We will seek to strengthen programs, policies and procedures until health inequities are eliminated.
- That if the strategy, practice, policy or procedure works for the most disadvantaged communities, it works for everyone.

We have made strides in weaving equity considerations into everyone's work. While not yet where we aim to be, we are making progress on our commitment to equity. However, there is an awareness of the need to lead with a racial equity lens. This report therefore builds upon the work of so many others at DHS and in the communities we serve.

Why focus specifically on U.S.-born Black Minnesotans

All racially minoritized communities in Minnesota experience health disparities in one or more chronic conditions, however, U.S.-born Black Minnesotans notably have among the worst outcomes (Breslin et al., 2021):

- Adults experience increased rates of diabetes, asthma, HIV, hypertension, cardiovascular disease, substance use disorder and post-traumatic stress disorder.
- Children experience increased rates of preterm birth, low birth weight/very low birth weights, asthma, obesity, anxiety, suicidal ideation, potentially preventable emergency department visits and preventable hospitalizations.

Fig 5. Structural racism's connection to U.S.-born Black health disparities

U.S.-born Black people are predominately descended from individuals and communities subjected to chattel slavery, Jim Crow segregation and mass incarceration. These features of structural racism directly contribute to the racial health disparities seen today (Fig 5). This legacy of chattel slavery is distinct to U.S.-born Black people.

Much of the available data understate the problems faced by U.S.-born Black Minnesotans, because the data clump immigrant and U.S.-born people together. As noted in the Minnesota Department of Health's 2019 report on culturally responsive care, the data "mask disparities impacting U.S.-born Blacks. This is in some part due to a healthy immigrant effect – a well-known phenomenon where immigrants are on average healthier than those who were born in the United States. The disparities are also attributable to structural racism and historical trauma that have negatively impacted outcomes across generations. We see these disparities between U.S. and foreign-born Black populations in Minnesota across education and health outcomes, such as: Minnesota Comprehensive Assessment test scores, high school graduation rates, infant mortality, and birth outcomes." (Minnesota Department of Health, 2019a)

Table 1 shows the notable health disparities between U.S.-born Black/African-American people enrolled in Medicaid programs compared with those who immigrated to the United States. Although the average age of enrollees in the two groups was the same, U.S.-born Black/African-American people had higher rates in every adverse outcome than those who immigrated to the United States. Between these groups, rates of asthma, heart failure/hospitalized heart conditions and depression were three times higher for U.S.-born Black/African-American people. And overall, U.S.-born Black/African-American people had the highest prevalence of asthma, hypertension, and heart failure/hospitalized heart problems of any group, and the second or third highest rates of many other medical or behavioral health conditions.

Changes in immigration law and the opportunities that came with it resulted in notable differences in how different communities who identify as Black interact with government institutions in the United States (Anderson, 2015). There are also differences in how other communities of color, refugees and other immigrant populations interact with government and medical institutions. Given the distinct current and historical contexts that have contributed to the health of Black communities in the United States, and in order to focus on specific community strengths and the opportunities to build racial equity from their perspective, this report focuses on U.S.-born Black communities. This decision was not uniformly embraced by members of the Black community in Minnesota. During Community Conversations, several participants questioned this approach, citing that the data around a healthy immigrant effect was incomplete and therefore inconclusive, making exclusion of Black immigrant and refugee populations unnecessary. Other participants felt strongly that disaggregation was important given what is known about U.S.-born Black persons' health. One overarching intent is that this approach will lay the groundwork for similar, iterative work with other communities in Minnesota, including Black immigrants and refugees, who also face structural barriers to realizing health and racial equity. It is also important to note that neither the Black immigrant nor U.S.-born communities are monolithic. The experiences of Black Minnesotans can and do vary by their geography, income, sexual orientation and gender identity and the other communities and beliefs they identify with. However the impact of structural racism is felt by all to some degree and this is what guides the focus of this report.

Throughout the rest of this report, the term "community" will refer to the U.S.-born Black community in Minnesota. To maintain accuracy, however, the report will at times use African American or Black when referencing statutes, regulations, research or other data sources that use those terms to define individuals who identify as Black from the U.S.-born community.

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	Enrollees who were born in the U.S.						Enrollees who immigrated to the U.S.					
Mortality and Morbidity	**American Indians***	**African Americans**	**Whites**	**Hispanics**	**Asians**	**Others/ Unknown**	**African Americans**	**Whites**	**Hispanics**	**Asians**	**Other/ Unknown**	**All MA Enrollees**
Mortality over 2.5 years	1.35	0.8	0.95	0.51	0.28	0.49	0.21	0.37	0.31	0.58	0.09	0.78
Type 2 Diabetes	12.37	8.28	6.19	7.6	4.9	5.32	7.66	7.54	10.88	9.71	6.52	6.95
Asthma	12.48	16.47	9.56	9.97	4.55	7.53	4.82	4.61	3.79	4.02	2.86	9.4
HIV/Hep-C	4.52	2.67	1.48	1.66	0.36	0.9	1.09	0.8	0.72	1.02	0.96	1.6
Hypertension	7.69	9.6	3.93	5.55	3	3.61	8.03	5.34	6.74	4.5	5.07	5.14
Heart failure, hospitalized heart conditions	2.05	1.96	1.46	0.65	0.57	1.08	0.64	0.96	0.79	1.27	0.59	1.37
COPD	11.91	8.4	10.17	6.72	2.98	6.33	5.1	5.65	3.92	4.46	2.74	8.53
Lung, Laryngeal Cancer	0.25	0.2	0.27	0.07	0.07	0.17	0.1	0.19	0.05	0.18	0.1	0.22
Behavioral Health												
Substance Use Disorder	35.37	20.09	15.64	14.12	4.33	12.34	2.56	3.75	3.97	2.78	2.37	14.42
PTSD	10.54	8.64	5.62	6.06	2.41	3.58	6.31	6.76	3.09	6.05	2.51	5.9
Depression	30.27	20.58	22.4	19.23	7.53	15.33	6.78	12.36	10.32	9.65	5.39	19.22
SPMI	7.36	7.09	6.19	4.77	2.94	3.68	2.73	4.47	1.59	5.48	1.38	5.55

Table 1. Prevalence of mortality and chronic conditions, by race/ethnicity and immigration status in Minnesota Medicaid enrollees, 2014. *All American Indians were included in this column. *Dark grey shading indicates the worst outcomes and light grey shading indicates the next worst. The values in the table are simple prevalence rates among all Medicaid enrollees, without any adjustments for other factors. For example, 6.95% of all Medicaid enrollees (in the far right column) had a diagnosis of type 2 diabetes.*

III. Levers within Medicaid to address racial equity for U.S.-born Black Minnesotans

In his book, "How to be an Antiracist," Dr. Ibram Kendi defines an antiracist policy as "any measure that produces or sustains racial equity between racial groups." When looking at how Medicaid policies can build racial equity for U.S.-born Black Minnesotans, DHS approached the work by considering four key "levers" of Medicaid policy development: eligibility/enrollment, access, quality and early opportunities.

These levers capture multiple decision points where racial equity can be embedded: Who is eligible for Medicaid? How do they enroll and re-enroll? Are they able to access the care they need? Does that care meet the community's definition of quality? What role does Medicaid play in providing health equity from the very start in our community?

Eligibility and enrollment

Federal and state Medicaid policies, county-worker capacity, availability of a navigator, the complexity of information technology (IT) systems, and many other variables influence who is eligible for Medicaid and how easy or difficult it is to enroll and stay enrolled. In addition, the personal resources of the applicant can also make it easier or harder to enroll. These factors include their language and reading proficiency, technological expertise, understanding of health insurance and financial terminology, home address stability, and knowledge of their familial and social support networks. Most Medicaid enrollees must renew and prove their eligibility at least once a year. An individual's eligibility is based on factors such as household income and assets, family size, age, disability status, and citizenship or immigration status. These criteria are set by federal and state law and vary by eligibility category. In Minnesota, income eligibility ranges from 100% to 283% of the federal poverty level (FPL) depending on other factors (Fig 6).

Despite being eligible for Medicaid, many people who would benefit from Medicaid coverage aren't enrolled at all or experience gaps in their coverage. Forty-nine percent of uninsured individuals in Minnesota were estimated to be eligible for public health insurance programs like Medicaid in 2019 (Minnesota Department of Health, 2021b). Nearly one in four Medicaid enrollees nationally have had to change coverage within one year, and a majority experienced a gap in coverage (Sommers et al., 2016). This has been attributed to how frequently states require Medicaid enrollees to renew enrollment or re-verify their eligibility, the amount of time states provide enrollees to respond and the income fluctuation among populations covered by Medicaid. One survey found that the experience of income volatility differed by the race/ethnicity of communities, with 38% of Black households, 45% Hispanic households and 32% of white households reporting some income volatility (Sugar et al., 2021). Another study noted that Black Medicaid enrollees were more likely than white enrollees to go off Medicaid for more than six months. Those who were off more than six months were less likely than those who stayed on to have a regular source of care, more likely to forego health care for financial reasons and more likely to report problems paying medical bills (Goold et al., 2020).

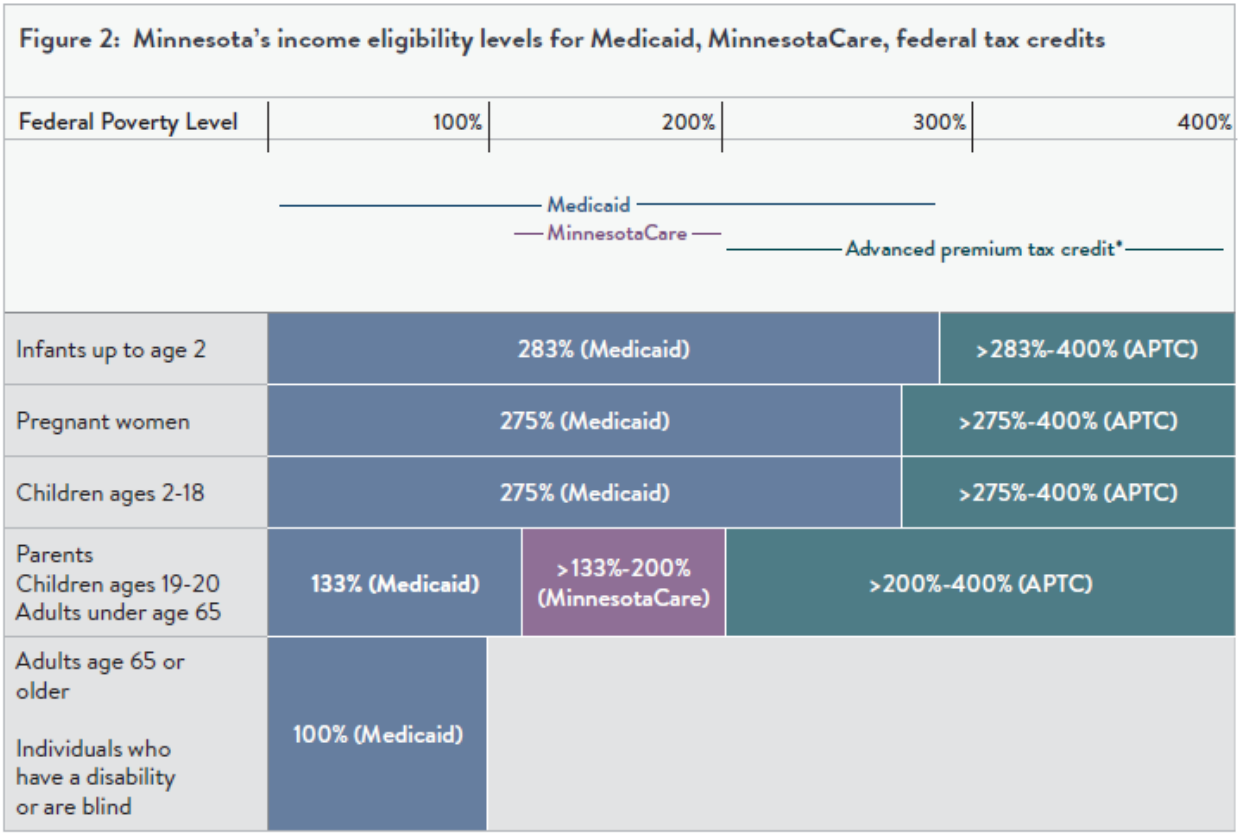

Fig 6. Minnesota's income eligibility levels for Medicaid, MinnesotaCare, federal tax credits * for 2021 and 2022, premium tax credits also apply to people above 400% FPG.

Access

Access refers to enrollees' ability to access care: Is there a primary care provider within a reasonable distance from home? Do they have access to culturally relevant care that is delivered with humility? Do they have reasonable access to specialists, behavioral health care or dentistry? There is ample evidence that access is a significant barrier for Medicaid enrollees. The Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of national household survey data has shown that "adults with Medicaid are more likely to report delayed medical care because of concerns about out-of-pocket costs, difficulty obtaining appointments, or because they do not have transportation" (MACPAC, 2021). Access to specific care like mental health providers can be especially inequitable. A 2014 JAMA study found that only 43% of psychiatrists accept Medicaid (Bishop et al., 2014). Barriers to care have been demonstrated among Minnesotans on Medicaid with a 2017 analysis of survey data showing that 55% reported some access barriers (Allen et al., 2017).

Access is a key lever to building racial equity within Medicaid. Black community members experience additional disparities in accessing care. The 2018 AHRQ National Healthcare Quality & Disparities Report noted that "12.3% of Black adults who had a doctor's office or clinic visit in the last 12 months and needed care, tests, or treatment sometimes or never found it easy to get the care, tests, or treatment compared with 6.8% of white adults" (U.S. Department of Health and Human Services, 2019). And while Minnesota DHS' 2021 Medicaid consumer satisfaction survey (Minnesota Department of Human Services, 2021a, c) found no difference in how Black respondents "felt judged or treated with disrespect by a health professional because of their race," they were statistically significantly more likely to be "told they showed up too late to an appointment to still be seen," a question Minnesota DHS added in 2021 as a proxy for missed opportunities for care. A 2017 analysis of Minnesotans on Medicaid found that 21% of enrollees who identified as U.S-born Black reported having foregone care in the past year, the highest percentage of any racial/ethnicity group surveyed. And Minneapolis and St. Paul both scored among the most segregated cities in the United States in 2019, according to the Othering & Belonging Institute at the University of California, Berkeley's *The Roots of Structural Racism Project* (University of California, Berkeley). This geographic segregation contributes to the barriers in access Black Minnesotans experience. For example, a JAMA study (Goedel et al., 2020) examining access to medication for opioid use disorder found that "counties with highly segregated African American and Hispanic/Latino communities had more facilities to provide methadone per capita, while counties with highly segregated white communities had more facilities to provide buprenorphine per capita." In Minnesota, buprenorphine is available in many primary care offices throughout the state while methadone at only 12 opioid treatment programs, highlighting the role geography and place play.

As the single largest payer for health care services in the state, Minnesota Medicaid has a critical role in driving increased racial equity in health care access, particularly in areas of care where Medicaid's footprint is largest, such as pediatric, obstetric and mental health services, and long-term services and supports. Given that nearly 80% of Medicaid enrollees are served by a managed care organization, it is also important that Medicaid work with, measure and incentivize managed care organizations' efforts to improve racial equity in access to care.

Quality

Once an enrollee successfully gets access to care, do they receive care at the same level of quality as other Medicaid members or other Minnesotans? Are the measures used to define "quality" consistent with what the community would define as "quality" care? It has been noted for more than a decade that enrollees in Medicaid managed care have significantly lower rates in common health care quality measures across the board compared to other payers (Minnesota Community Measurement, 2021a). Among Medicaid enrollees, Black/African-American members consistently experience even lower rates on a majority of measures than other groups of enrollees (Table 2). Minnesota Community Measurement's 2020 report on Health Care Disparities by Race, Hispanic Ethnicity, Language and Country of Origin states that "Black patients whose preferred language is English have significantly lower rates of optimal diabetes care, optimal vascular care, and depression remission at six months compared to Black patients whose primary language is not English" (Minnesota Community Measurement, 2021b). This speaks to additional barriers U.S.-born Black Minnesotans may face receiving the same level of

quality care in Minnesota. It also highlights the need for further disaggregation of race and ethnicity data used to measure quality and other metrics within the Medicaid program. Currently, Medicaid has racial demographic data for 93% of enrollees. To truly understand inequities in the quality of care received by Medicaid enrollees will require their trust in sharing their race and ethnicity data. Part of building that trust is having communities define what "quality care" actually entails.

MEASURE	2020 MHCP MCO Race Average*	RACE										2020 MHCP MCO Ethnicity Average*	ETHNICITY		
		Asian	Black	Indigenous/ Native	Multi Race	Native Hawaiian/ Other Pacific Islander	White	Chose Not to Disclose/ Declined	Patient Reported Race Unknown	Some Other Race	Unknown Race		Hispanic/ Latinx	Not Hispanic/ Latinx	Ethnicity Not Reported
PREVENTIVE HEALTH MEASURES															
Breast Cancer Screening	64.2%	▲	▼	▼	●	●	●	-	-	-	●	63.3%	▲	●	▼
Colorectal Cancer Screening	59.7%	▲	▼	▼	●	●	▲	▼	▼	●	-	59.7%	●	●	▼
CHRONIC CONDITIONS MEASURES															
Optimal Diabetes Care	35.6%	▲	▼	▼	▼	●	●	●	●	▲	-	35.8%	●	●	●
Optimal Vascular Care	47.2%	▲	●	▼	●	NR	●	▲	NR	●	-	47.5%	▲	●	NR
Optimal Asthma Control - Adults	45.2%	▼	▼	▼	●	●	▲	●	▼	●	-	45.2%	●	●	▼
Optimal Asthma Control - Children	53.4%	▼	●	▼	●	●	●	▼	▼	●	-	53.9%	●	●	●
MENTAL HEALTH MEASURES															
Adolescent Mental Health and/or Depression Screening	89.4%	●	▼	●	●	●	▲	●	▲	●	-	87.8%	▼	▲	●
Adult Depression: Follow-Up PHQ-9/PHQ-9M at Six Months	48.5%	●	▼	▼	▼	NR	▲	▼	▼	●	-	48.3%	▼	●	▼
Adult Depression: Response at Six Months	15.9%	●	▼	▼	●	NR	●	●	▼	●	-	15.8%	●	●	●
Adult Depression: Remission at Six Months	8.3%	●	▼	▼	●	NR	●	●	●	●	-	8.3%	●	●	●
Adolescent Depression: Follow-Up PHQ-9/PHQ-9M at Six Months	41.8%	●	▼	●	●	NR	●	●	NR	●	-	41.4%	●	●	NR
Adolescent Depression: Response at Six Months	13.1%	●	▼	●	●	NR	●	●	NR	●	-	13.3%	●	●	NR
Adolescent Depression: Remission at Six Months	6.3%	●	●	●	●	NR	●	●	NR	●	-	6.3%	●	●	NR

▲ Significant above statewide MHCP MCO race/ethnicity average ● Average ▼ Significantly below statewide MHCP MCO race/ethnicity average

NR = Not reportable. Did not meet minimum reporting threshold of at least 30 patients - Race category not reported for HEDIS/DDS measure

*Statewide MHCP MCO rates were re-calculated for those with race/ethnicity information available.

Table 2. 2020 Comparison of Minnesota Medicaid managed care enrollees' quality metric rates by race and ethnicity. *Source*: *Minnesota Community Measurement's 2020 Minnesota Health Care Disparities by Insurance Type report*

Early opportunities

Prenatal, maternal and early childhood health and development also play a significant role in the emergence of racial health disparities. In Minnesota, about eight in 10 births to mothers who identify as

Black are to people insured by Medicaid. Yet data from Minnesota Vital Records showed that between 2011 and 2017 African American/Black birthing people were 1.5 times more likely to die during pregnancy, delivery or the year post-delivery than non-Hispanic white birthing people. More specifically, U.S.-born African American/Black women are 2.8 times more likely to die during pregnancy, delivery, or the year post-delivery than non-Hispanic white women (Minnesota Department of Health, 2019b). Other studies have shown that Black pregnant women have a substantially lower likelihood of receiving any medication for the treatment of opioid use disorder, and when they do receive treatment, they have a lower likelihood than white non-Hispanic pregnant women of receiving buprenorphine treatment compared with methadone (Schiff et al., 2020).

Minnesota also has some of the nation's worst disparities in birth outcomes for Black people. Black birthing people have higher rates of giving birth prematurely (9.3%) than white birthing people (8.6%) as well as having a newborn with low birth weight (9.5% and 5.9%, respectively). Among births covered by Medicaid in 2019, the low birth weight rate was 6% for white birthing people, and 12% for U.S.-born Black birthing people with the preterm birth rate landing at 9 and 12%, respectively. Prematurity, low birth weight and neonatal opiate withdrawal are the leading causes of costly neonatal intensive care unit admissions. These adverse birth outcomes are strongly associated with lifelong health problems like illnesses that affect breathing, feeding and digestive problems, cerebral palsy, and intellectual and developmental delays that lead to challenges in school.

The environment and level of support children are raised in during their first five years is critical to reaching their full potential. Early experiences shape brain development in a way that impacts not only education and school readiness, but lifelong health (Center on the Developing Child at Harvard University, 2017). Minnesota has numerous opportunity gaps when it comes to providing an equitable start for our youngest Minnesotans (Chomilo, 2019). Minnesota Medicaid has previously participated in grant-funded planning work around a newborn child's first 1,000 days on Medicaid that identified several key areas critical to provide them with an ideal start: integrating cross-sector data, identifying assessment tools and shared metrics, building state and community-level cross-agency partnerships, creating new clinical models and community linkages to medical practices and targeting highest risk infants, families and neighborhoods (Somers & Maul, 2021). Black children are among the groups more likely to experience interruptions in coverage, which has been shown to lead to delayed care, unmet medical needs and unfilled prescriptions (Olson et al, 2005). As noted earlier, in Minnesota 64% of Black children are covered by Medicaid (Fig 7). Therefore focusing on how we explicitly build racial equity into eligibility/enrollment, access, and quality for our mothers and youngest Minnesotans is critical. A failure to address racial equity in maternal and early childhood policy will set the health and opportunities presented to Black children on a different trajectory and make the state's commitment to equity that much more difficult to achieve.

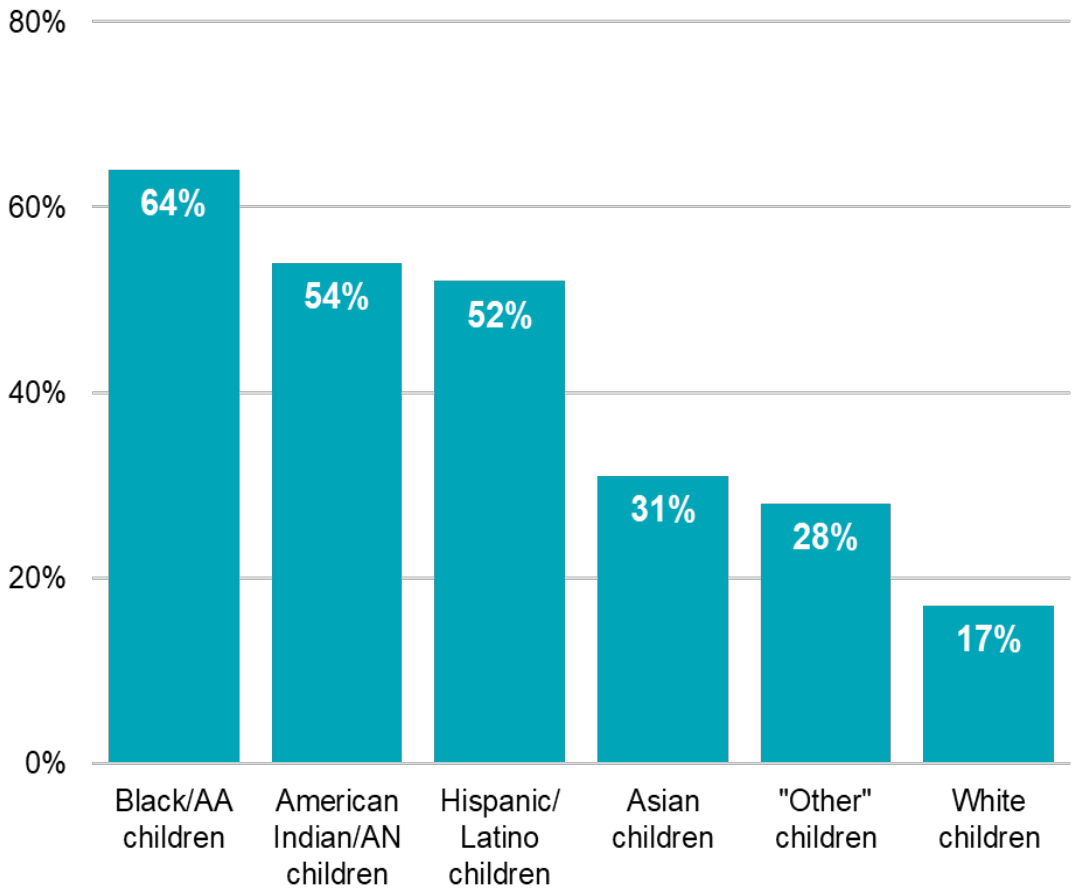

Fig 7. Percent of Minnesotan Children with Medicaid as source of coverage, by race, 2017-2018

Source: SHADAC analysis of the 2017-2018 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Note: Data years 2017 and 2018 were combined to increase the sample size and improve the reliability of estimates among Minnesotans by race and ethnicity.

IV. What Medicaid can do now to address racial equity for U.S.-born Black Minnesotans

The result of the iterative process described above, this report lays out the Medicaid policies and programs most commonly cited by the U.S.-born Black Minnesotan community members involved: Enrollment and renewal, access to culturally-relevant care, and community engagement and co-creation. The report shares the problem as well as opportunity in each of these areas. It then tries to answer the following questions: Why does the problem exist? What has Medicaid done to address it? And finally, the report provides one to two "Calls to Action" that are needed right now to build racial equity into the walls of the Medicaid program along with potential indicators of progress to set some initial degree of accountability.

What will accountability to U.S.-born Black Minnesotans look like for Medicaid?

Recognizing that changes in Medicaid policy can require state or federal legislative authority or funding, accountability for the Calls to Action covered below can be difficult to place. These call outs intend to present broad outcomes that the Medicaid agency within DHS can be accountable to with the U.S.-born Black community in Minnesota. The aim of that accountability is to be Medicaid-focused and on the outcome of racial equity and not just the process. The Calls to Action are some of the ways proposed to improve racial equity for U.S.-born Black Minnesotans based on the iterative process involving community members and DHS staff. However, many actions can realize racial equity. The process is important, but accountability ultimately comes from a change in outcomes.

Importantly, since Medicaid service eligibility cannot currently be dependent on an individual's racial background, none of these calls to action seek to create Medicaid-funded services that are racially exclusive. Instead, they recognize the long overdue need to ensure policies, programs and the administration of each are done with awareness and action toward racial equity. With that frame as a guide, focusing the agency's efforts on changes, which will be available to all, and the communication of these changes to communities most impacted by structural racism, can notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

Enrollment and renewal

What is the problem, and why does it exist?

U.S.-born Black Minnesotans enrolled in Medicaid programs often talk about challenges they face in enrolling in Minnesota Health Care Programs (Medicaid and MinnesotaCare).

Public programs of all types are criticized for difficult enrollment processes. There are many reasons for this, including complex federal and state eligibility rules, requirements for extensive documentation, the need to go to a county or tribe or to use an online system to apply. Medicaid enrollment is no exception.

Many barriers exist outside of DHS' control. However, there are some barriers which DHS, in collaboration with agency partners, could improve upon.

In interviews with families with children who were living in poverty (DHS, 2020) (Minnesota Department of Human Services, 2020), of the 27 parents asked about health insurance, six (22%) appeared to be income-eligible for Medicaid but were not enrolled. This was concerning as all six families had significant health care needs. Two parents were pregnant or just had a baby, one parent had diabetes, and three parents had serious mental illness.

Some of the uninsured parents were confused by the Medicaid enrollment process. Two parents had submitted applications but were unsure where they were in the process. For example, a mother of two teenagers has urgent needs for health care. She has diabetes, and she wants help for one of her children who is having emotional outbursts.

> *"We applied for MNSure, but I didn't do it through there. I did it on paper. They say it's backed up on paper, so I should have done it online because it's quicker. I wonder if I should do it online. But they said what would happen is I would get knocked off the list for already having it. It's confusing."*
>
> — *Female, African American*

When she contacted the consumer helpline to find out why her paper application was taking so long, they were only able to tell her that it was being processed, and did not seem to have access to any other information. This is probably because the county was processing her application, and DHS did not have up-to-date information on it. However, it is frustrating for applicants to call the DHS Health Care Consumer Support line and be unable to get questions answered about their particular case.

Enrollment and renewal: Lack of communication with applicants and enrollees

Once a person has enrolled, DHS needs to continue keeping them up to date on their case, and there are many indications that this does not always happen. The Improve Group conducted interviews with people in the Twin Cities area who were living in poverty, people who are homeless and people who have immigrated (The Improve Group, 2016). They noted that several people described going to a health care appointment or to a pharmacy to fill their prescription, and were surprised to learn that they had lost their Medicaid coverage. As a result, they sometimes had to go without the care or the medication. One woman described this experience.

> "It was difficult to get MA [sic]. The first time I applied for MA it took 2-3 months to get it, but it was a while longer before I got my card. Then I had it and they cut me and my kids off, I don't know why. I was only on MA a couple months, and they said I needed a renewal, so I did my renewal but went to get my birth control and my MA was inactive."
>
> — Female, African American, 18-25 years old (MA stands for Medical Assistance, Minnesota's Medicaid program)

The Improve Group also described some situations where the paperwork to renew a person's Medicaid eligibility found its way to them *after* the renewal deadline, so they lost their coverage. Others described

discovering that they had been moved to a different managed care organization and didn't understand how this happened or if their benefits changed.

In a discussion with DHS staff who attended a 2020 presentation on how chronic stress adversely impacts clients, many were aware of and concerned about a lack of communication, and described the challenges noted above from their own points of view. Staff in one of the help desk areas noted that "the frustration of having to make multiple calls and wait to get one's questions answered is exacerbated by the urgency of people's questions … People are already in a state of stress when they are contacting DHS — often with health conditions that they need to see a doctor for."

In these first-hand accounts, people had many complaints about the enrollment system, but they often seemed most upset by the lack of communication. Their application was stalled and they couldn't find someone who could tell them what was going on, even when they called the help desk. Their coverage was dropped, and they only found out about it when they tried to get health care. These comments suggest that even if the application form is complex and the methods for applying are less than ideal, DHS could make the application process much less frustrating if there were reliable ways for applicants to get all of their questions answered and for them to get regular updates on their application and renewals. One way this might be improved is if DHS stopped relying exclusively on paper notices that are sent through the mail and made notices available online. If these could be accessed through a mobile phone or other modes of communication, people might be more likely to receive them when and where they need them.

Enrollment and renewal: Opportunities and strengths identified by community

Multiple sources suggested the value of having navigators help people apply for coverage through the MNSure portal. Navigators are located within health care systems, county or tribal human services agencies, and trusted community nonprofits. They help people apply, enroll and manage their paperwork and will sometimes help people find a health care or other provider. They play an especially important role in helping people overcome technology barriers when applying for coverage online through MNSure. This is particularly valuable for people without a computer or internet access at home. The paper application alternatives require completing and mailing in or dropping off a form, and then waiting for the county or tribal agency to process the form and send notice of the determination. However, access to a computer and internet is far from universal; only 69% of African Americans in the United States have a computer at home, and 71% have broadband internet (Pew Research Center, 2021) (Atske & Perrin, 2021).

As mentioned by the Community Wellness Center staff, navigators can be located within culturally-specific organizations. Working with a member of their community can be important for Black Americans, given the unethical treatment they received historically from the medical industry (e.g., the Tuskegee syphilis study) as well as the unequal treatment that continues today (Epstein et al., 2000; Petersen et al., 2002). Working with a trusted individual who shares a common history with them may make it more comfortable to share sensitive information about themselves, and thus enable the navigator to help them access all the services they need.

The Improve Group (The Improve Group, 2016) found that "participants who received help applying for coverage from MNsure navigators reported a far better experience and fewer challenges in getting started with MA than those who did not" (p. 20). In a discussion with the Cultural Wellness Center, their staff lauded navigators as providing people with help to enroll, but also to help guide families to other services they may need. They emphasized that their value comes from their location within the community, and living and working alongside the families they support.

Two of the stakeholder groups named continuous enrollment as a potential solution. The African American Leadership Forum expressed interest in the idea of continuous enrollment at a state or even a federal level, and asked what it would take to make that happen. This group also asked whether it would be possible to give more leeway to people who were enrolled but have a lapse in enrollment due to a glitch in the notification process. Leaders in the Center for Economic Inclusion asked about auto enrollment or auto re-verification of these programs. Participants of the Community Conversations hosted by DHS also deemed continuous enrollment important. Of all the Calls to Action, participants were most excited about proposals to extend periods of continuous enrollment among enrollees.

Enrollment and renewal: What is Medicaid doing to address this?

One of the ways DHS has tried to support people applying for Medical Assistance, is to ensure that community navigators stay in business during the COVID-19 pandemic. DHS staff learned from the Navigator Coalition that navigators were adversely impacted by significant funding shortfalls. The steps DHS took to help Minnesotans maintain health care coverage during the emergency resulted in a steep decline in the number of new applications and suspended virtually all renewal activities. This caused a decrease in navigator incentive payments, funds navigators receive when they help applicants and enrollees successfully apply and renew health care coverage. DHS sought and the Minnesota Legislature approved a state law change to distribute unused 2021 incentive payment funds as grants to help support navigators during the pandemic. It is critical that navigators remain available to assist enrollees when standard eligibility and enrollment activities, particularly annual renewals, resume at the conclusion of the public health emergency.

DHS plans to make the Medicaid application process simpler by allowing people to apply using an online portal and phone app called MN Benefits. This tool allows Minnesotans to simultaneously apply for programs such as SNAP (food stamps), MFIP (cash assistance for families with children), emergency assistance, housing support, and child care support. This tool could allow people to apply for Medicaid at the same time. DHS has received positive feedback from users on the tool's ease of use. At the time of this report's publication, DHS is in the planning phase of this work.

Improving Medicaid enrollment and renewal policies for justice-involved populations provides another step in improving racial equity among Medicaid enrollees. In 2015, Black Minnesotans were incarcerated 9.1 times more than white Minnesotans. While research shows that this disparity in incarceration rates contributes to racial health disparities (Wildeman & Wang, 2017), it also points to how increased access to care may lead to improved outcomes, such as decreased hospitalization or recidivism (Guyer et al., 2019; Plotkin & Blandford, 2017). No federal law, statute, regulation or policy prevents individuals from being enrolled in Medicaid before, during or after incarceration in jail or prison (McKee et al., 2015).

However, under federal regulations, federal Medicaid funds may not pay for services provided to people who are inmates of a public institution, other than for inpatient hospitalization. As a result, Minnesota has traditionally terminated people's Medicaid coverage upon incarceration. This requires them to reapply for Medicaid when they are about to be released, which can be very challenging to do from prison.

During the COVID-19 emergency, DHS put in place a procedure to ensure that Medicaid enrollees remain enrolled in Medicaid without interruption, creating a special code to ensure that Medicaid funds only inpatient hospitalization. Under this new policy and procedure, Medicaid enrollees remain enrolled during incarceration and have full coverage restored upon release. DHS is currently working to make these changes permanent in all Medicaid eligibility systems.

What will accountability to U.S.-born Black Minnesotans look like for Medicaid in enrollment and coverage renewals?

- Advancing proposals to change Minnesota laws regarding continuous eligibility for those aged 0-19.
- Taking demonstrable steps to improve enrollment and renewal processes.
- Continuing to support navigators.
- Making renewal notices more accessible to enrollees, e.g., available electronically in addition to mailed paper documentation.

Outcome: Minimal disparity in the percent of U.S.-born Black Minnesotans who maintain coverage at the end of the federal public health emergency compared to average Medicaid enrollees.

Call to Action: Simplify and support enrollment and re-enrollment

DHS eligibility policy and operations staff have many ideas for making enrollment easier, preventing lapses in eligibility and communicating more effectively. Many of the recommendations simplify the application process but require significant technical changes to the Minnesota Eligibility Technology System (METS). Given the high costs, lengthy timelines and even lengthier queues for any modifications to the online system, these recommendations must be thought of as long-term goals, and they are identified with an "IT" indicator. Other ideas could be implemented in the shorter term, especially once changes are completed to bring the system back to pre-pandemic rules. Based on iterative discussions with community and DHS staff, DHS should focus on two steps to simplify and support enrollment and renewal in a way that will improve racial equity for U.S.-born Black Minnesotans on Medicaid in the near term:

1. Pursue continuous eligibility policies

Continuous eligibility (also referred to as continuous enrollment) allows enrollees to maintain their enrollment regardless of changes in circumstances for up to 12 months at a time.

Twelve-month continuous eligibility for children is a long-standing retention strategy for states, and 32 states already offer this (Medicaid, 2021). The Social Security Act currently gives states the option to provide continuous eligibility to children under age 19 for up to 12 months. This means that the child's enrollment cannot end, regardless of any changes in circumstances, unless the child

- a) reaches the end of the 12-month period and is no longer eligible;
- b) reaches age 19;
- c) ceases to be a state resident; or
- d) passes away.

States also have the flexibility to tailor continuous eligibility for children to the specific needs of the state, such as choosing the age range for continuous eligibility and length of the continuous eligibility period. For example, Florida provides continuous eligibility for 12 months for children under age 5, while children ages 6 through 18 receive six months of continuous Medicaid eligibility (Kaiser Family Foundation, 2020). Indiana provides 12 months of continuous Medicaid eligibility only to children under 3 years old (Kaiser Family Foundation, 2020).

Minnesota has no continuous eligibility policy yet for children. However, Minnesota currently provides continuous eligibility to pregnant people (recently extended in the 2021 legislative session from 60 days to 12 months following the end of pregnancy) and their newborns through the first year of life. Philosophically, adding continuous eligibility for children is the logical next step. Providing continuous eligibility to children reduces churn during the year, which is administratively expensive and a barrier to children getting needed care (Brooks, 2021). In addition, changes that may be temporary or permanent, such as a new job or taking on more hours of work during the busy season, would not impact children's eligibility until their next annual renewal. Continuous eligibility could also benefit the entire family by keeping the family's case open even when adult family members lose eligibility. Once a family's case is closed, they have to complete a new application to reapply. If their child had continuous eligibility, parents whose eligibility is terminated due to a change in circumstances or for failure to comply with an eligibility requirement could be reinstated on their child's case if they become eligible again during the year or at the next renewal without having to complete and submit a whole new application. Given the many ways outlining how structural racism impacts families of color, it is little surprise that gaps in coverage due to churn are more likely to impact Black and Hispanic children, with this report also showing that the Midwest had one of the highest gaps in coverage by region (Alker & Osorio, 2021).

The importance of continuity for children is further emphasized by its inclusion in the federal Build Back Better Act, which at this writing has been passed by the House and is being considered in the Senate. While states currently have the option to provide continuous eligibility to children under age 19 through the Social Security Act, this bill would make it a *requirement* for states to do so. All children under age 19 eligible for Medical Assistance would receive continuous enrollment for a 12-month period, beginning on the date of the determination of eligibility. States will no longer have the option to limit the child's age or the time length of the continuous eligibility period.

If this bill becomes law, it will require changes in the IT systems at both MNsure (METS) and the system used by counties (MAXIS). However, even if the Build Back Better Act is not passed, **DHS should pursue**

the state plan option under the Social Security Act to provide continuous eligibility to children. This can be accomplished by submitting a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) for approval. When given the option, Minnesota should choose to provide the full 12 months of continuous eligibility to all children under age 19. This aligns with the continuous eligibility period for both pregnancy people and newborns.

Additionally, DHS should pursue additional expansion of continuous eligibility. Given what is known about the importance of the first five years on early brain development and what has occurred in the past two years during the COVID-19 pandemic, **DHS should explore an 1115 Medicaid Demonstration Waiver to implement 72 months of continuous eligibility for children on Medicaid up to age 6 and establish 24-month continuous eligibility for all enrollees age 6 and older.**

Both of these changes have recently been proposed by Oregon's Medicaid Agency, the Oregon Health Authority, in its 2022-2027 1115 Medicaid Demonstration Waiver proposal (Oregon Health Authority, 2021). In it, they note that 72-month eligibility for children up to age 6 will, "stabilize their insurance coverage and thus increase access to early-childhood screenings and necessary treatment … reduce frequent enrollment and disenrollment in this vulnerable population and allow for more predictable access to care, which is an important driver of improved health. Because many of these children remain eligible for coverage, eliminating churn also reduces state administrative costs and burden for families in application reprocessing. Further, expanding the pool of children who are continuously covered may ultimately reduce per member costs of coverage, as children who stay on OHP [Oregon Health Plan] longer will have better access to preventive and primary care services that can reduce the need for higher-cost treatments due to delayed care. Increasing the time between eligibility reviews for other family members will further ease the administrative burden on families and increase coverage stability for individuals and families on OHP." Regarding 24-month continuous eligibility for all enrollees age 6 and up they argue that, "Establishing continuous enrollment and increasing the length of time between eligibility renewals will preserve the coverage continuity gains achieved in the wake of federally enacted COVID relief bills passed in 2020. In 2018 and 2019, nearly 25% of new OHP enrollees had been enrolled in OHP within the previous 6 months. Over the last 6 months of 2020, this rate fell to just 5% of new enrollees. The speed with which people re-enrolled in OHP suggests that they may have been losing OHP coverage despite being eligible. The drop in the new enrollee rate suggests that federal policies enacted around the pandemic to keep people covered successfully reduced Medicaid churn."

2. Support navigators and simplify the enrollment and renewal process

Comments on the enrollment process emphasized applicants' frustration that they were not kept up to date on the progress of their applicati*on, and that help desk staff were unable to answer questions on their particular case.* People also felt frustrated that they received no notification when a change had occurred, e.g., they lost coverage. Given the complexity of enrolling and renewing coverage, how many people in poverty lack a home computer with internet access, and that navigators are located within communities, increasing the availability and utilization of navigators is an important way to help people to apply. Navigator funding comes from contracts with counties, health care systems or other organizations. **DHS should therefore work with navigators and the U.S.-born Black community to**

develop a plan focused on ensuring eligible Black Minnesotans gain or maintain Medicaid coverage throughout the year but in particular as the federal public health emergency ends.

Access to culturally relevant care

What is the problem?

"Culture is missing"

— Community leader

Improving eligibility and enrollment in Medicaid and the care it covers is not synonymous with improving care and access for all communities. Studies of the impact of Medicaid expansion under the Affordable Care Act have had mixed results when it comes to decreasing racial disparities in several markers of access and care (Guth et al., 2020). A participant in the Community Conversations reflected, "They [medical practitioners] don't listen to us [Black people] when we explain our problems; Black patients do not receive the same treatment as white patients." A significant amount of literature validates the lived experience shared by this community member, both in how Black adults (Ayotte & Kressin, 2010; Federspiel et al., 2011; Angraal et al., 2018; Hsia et al., 2011; Mortensen et al., 2004; Green et al., 2007) and children (Todd et al., 2000; Goyal et al., 2015) are the recipients of unequal care. The 2017 analysis of Minnesotans on Medicaid found that 49% of enrollees reported experiencing some discrimination (described as unfair treatment due to gender, ability to pay, enrollment in Medicaid, or race/ethnicity/nationality). This highlights the need for systems of care to be intentional about connecting community members to health care professionals who provide culturally relevant care. As another community member shared during the Community Conversations, "relational care matters more than some medical care."

This sentiment was echoed in meetings with multiple community leaders who stressed the importance of culture in the health and well-being of community members. Culture was described as the fabric that links an individual to their community through shared beliefs, knowledge, practices and protections. Loss of culture in the healing space therefore contributes to illness by separating an individual from one of their shared strengths. This has been seen over time by racist policies that attempted to strip communities of their culture and codify a white supremacy approach to health as the only legitimate path (United Nations, 2016; Edwards, 2021; Yearby, 2020; Crear-Perry et al., 2021). In the face of this, many communities, including the U.S.-born Black community, have maintained their culture and the strength that comes with it. Health care systems are only beginning to value this resilience, and access to care that honors culture remains difficult.

MDH noted in its 2019 report on Culturally Responsive Care that "Cultural competency is critical to providing equitable, effective and respectful care and services. It includes but is not limited to being responsive to diverse beliefs and values related to health and wellbeing, delivering services in preferred languages, and being mindful of health literacy and numeracy. Providing culturally appropriate care is increasingly important as Minnesota becomes more diverse … Providing culturally responsive care to U.S. born black women and children living in Minnesota includes (but is not limited to) acknowledging

the historical trauma that has affected black communities in Minnesota and the current oppression and racism that restrict access to resources, education and health care."

Lastly, one of the ways to identify and prioritize culturally relevant services is via information technology systems. Unfortunately, many remain archaic and were not designed with the end user in mind. Culturally specific data needs to be integrated into technology systems. Modernization of these systems is complex, bringing with it multiple layers that may from the outside appear simple. Adding to this is that until relatively recently differences between the U.S.-born Black community and Black immigrant and refugee communities weren't acknowledged and therefore these communities have not been involved as end users in conversations about developing an equitable IT infrastructure.

Access to culturally relevant care: Opportunities and strengths identified by community

Community leaders emphasized a strong need for culturally specific care in conversations. Panelists consistently discussed the important role culture plays in an individual's health and a community's health. One interviewee called for a new definition of health that emphasizes a community's (cultural group's) ability to care for each other. Trauma-informed care also emerged as a theme in many conversations. In health care, trauma is often understood as specific events and their impacts on an individual's life and wellbeing. However, when a cultural lens of health care is applied, trauma can be viewed in a macro-sense and the impacts of historical and systemic racism become very relevant. Many DHS interviewees discussed the pressing need for more focus, training and attention on historical and ongoing trauma. Community interviewees noted that Medicaid and other state agencies can support culturally relevant care in concrete ways, such as incentivizing and building a stronger infrastructure of Black clinicians and clinics centered on care that values culture along with an allopathic approach to health and healing.

Access to culturally relevant care: What is Medicaid doing to address this?

Recognizing the problem and addressing it are two different things. Among DHS staff, a consistently noted barrier to addressing culturally relevant care was a lack of routinely and standardly disaggregated racial demographic data — data that would allow a better understanding of where specific communities experienced barriers and successes. Without good data, even staff aware of issues creating barriers found it very difficult to prioritize specific communities, health plans or providers with interventions (e.g., quality benchmarks, payment withholds, incentives).

Many DHS staff also observed the lack of trauma-informed providers in the community. It was also noted that most trauma-informed practices are not well designed to capture the historical and ongoing trauma that can often face U.S.-born Black community members.

Physicians who share the same racial background as the communities they serve often improve culturally relevant care. Reduced racial discrimination and bias is one of the cited reasons that racial provider-patient concordance, where providers and patients share the same racial background, has been shown to impact outcomes positively for Black patients (Shen et al., 2017; Greenwood et al., 2020). In Minnesota, although Black residents make up 7% of the general population, only 2.6% of Minnesota physicians and 1% of physician assistants identified as Black or African American in 2019

(Minnesota Department of Health, 2019c). Care provided by paraprofessionals who live in the same communities as patients experiencing disadvantage has also been shown to decrease disparities (Redding et al., 2014).

DHS has attempted to foster more culturally relevant care via non-licensed paraprofessionals who are more likely reflect the diversity of their patients. DHS staff observed that the agency has expanded coverage for doulas, community health workers (CHWs) and community emergency medical technicians (EMTs). Unfortunately, these benefits are not highly used. In partial response, DHS increased doulas' reimbursement rates. But in addition to reimbursement, DHS realizes it, and its county and managed care partners, must find ways to support the development of a community-based workforce and the awareness among Medicaid providers that these services are available and clinically beneficial.

Minnesota Medicaid's approach to improving culturally relevant care is evolving. There are several ongoing efforts to improve the race and ethnicity demographic data of our programs but nothing focused on disaggregating Black community members. Similarly, no specific withhold measures or incentives are in place to target U.S.-born Black enrollees or culturally specific care delivery. The Integrated Health Partnerships (IHP) program (Minnesota Department of Human Services, 2021b) does have requirements that participating partnerships have a patient board with representation from the community it serves, however there is no specific racial group requirement. DHS highlighted the importance of racial equity and culturally specific needs for Black pregnant people in its most recent managed care request for proposals for pregnant people and children and is looking at ways to decrease barriers to non-licensed provider participation in Medicaid.

What will accountability to U.S.-born Black Minnesotans look like for Medicaid in access to culturally relevant care?

- Ongoing development and funding of programs that include a U.S.-born Black Minnesotan-specific focus
- Contracting with managed care and other organizations that provide culturally relevant training to Medicaid providers.

Outcome: Increase in number of and utilization of culturally specific providers.

Call to Action: Increase investment in culturally relevant care

A culturally specific lens to health can better orient systems to strengths instead of deficits. Instead of asking where the most illness is seen, the focus can be on where health is seen — particularly in spite of numerous systems that have been built to a community's disadvantage. Viewing health through this lens is crucial as DHS aims to continue to rebuild trust that has been violated and whose loss has contributed to the inequities occurring today. Based on the iterative discussions with community and DHS staff, DHS should focus on two steps to address access to culturally relevant care for U.S.-born Black Minnesotans on Medicaid in the near term:

1. Invest in an internal structure that has a specific focus on U.S.-born Black Minnesotans

As illustrated above, within government, U.S.-born Black people face structural disadvantage yet do not have any specific institutional power. To address generations of structural inequity will require sustained intention. A dedicated internal structure could provide a direct connection to U.S.-born Black Medicaid enrollees, community-based organizations and other institutions to inform and co-create policies and programs that elevate strengths and address inequities. A division focused on Black Medicaid enrollee health could also ensure that efforts throughout DHS and other state agencies, e.g., the Minnesota Department of Health, are leveraging all available funding sources to close the gaps seen in health outcomes. Participants in Community Conversations expressed a desire for DHS to find ways to incentivize or require larger health care and insurance companies to train their employees and clinicians on how to engage with people of color. They also seek accountability measures around disparities in outcomes and experiences of racial discrimination. While engaging physicians and other licensed providers, DHS staff from this division could also ensure Medicaid providers are aware of the evidence and efficacy of referring their patients to culturally relevant services and paraprofessionals, such as doulas, CHWs and community EMTs. Staff dedicated to health services utilization research would be able to identify which services are being used, when and where, as well as highlight successes and opportunities to improve. Importantly, since Medicaid services cannot currently be granted solely on the basis of an individual's racial background, this division wouldn't create racially exclusive policy or programs. Rather, it would help focus the agency's efforts around changes that will be available to all yet notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

There is some precedent for this approach. In April 2020, DHS launched the African American Child Well-Being Unit to help address structural racism in the child welfare system by providing oversight and assistance to county agencies as well as grants to community-based organizations working with African American families.

Recently passed legislation improving the allergy and asthma benefit set for Medicaid enrollees might serve as an example of what this division could do on a much more regular basis. The legislation aims to address health disparities for those living in urban areas. The bill seeks to improve health outcomes for children with asthma and reduce asthma-related emergency room visits and hospitalizations. This is accomplished through reimbursement for environmental specialists to complete home evaluations and coverage for certain equipment and supplies ordered in the evaluation (e.g., allergen-rated air filters, dehumidifiers, HEPA air cleaners). An analysis of adult Medicaid enrollees age 18-64 found that U.S.-born African Americans had dramatically higher rates of asthma (16.5%) than any other racial or ethnic group (Minnesota Department of Human Services, 2018). It is therefore noteworthy that this legislation was initiated by the community and included the American Lung Association, Ramsey County, the city of Minneapolis and the Minnesota Department of Health based on a program previously piloted in Ramsey County. A division with a U.S.-born Black Minnesotan focus could therefore conduct a retrospective evaluation of this legislation, and others similar to it, to identity what critical components could be applied to other racial inequity-related projects. Domains for consideration could include legislation, resource allocation, community support, constituent engagement and political will.

Another example of what the division could focus on is how services intended to address social drivers of health perform in the U.S.-born Black Minnesotan community. In July 2020, DHS launched Housing Stabilization Services, an innovative and nation-leading Medicaid home- and community-based service to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. Interest and enrollment has far outstripped the initial projected estimates. A division with a U.S.-born Black Minnesotan focus could ensure that U.S.-born Black Minnesotans know about this benefit while taking steps to create more culturally specific features in the benefit to improve racial equity and inform other policy development around the social drivers of health.

2. Continue to prioritize standardization and disaggregation of race, ethnicity and language data

Race, ethnicity and language (REL) demographics of communities are among the few ways systems can get some insight into the impact of and need for culturally relevant care. While an incomplete and imperfect proxy for culture, REL data can serve as an important initial signal and inform conversation and collaboration with communities. One Community Conversation participant noted a need to "proactively identify data — there's not enough data, and the way we collect data is not moving at the same speed as how diversity is increasing." In fact, many of the reflections and solutions proposed by participants in the Community Conversations would rely at some point on precise REL data. Ideas such as assessing if a health plan's network of providers reflects the communities they serve or tying payment incentives or withholds based on decreases in racial health outcome gaps require reliable REL data. To use as much information as possible about where gaps persist, Medicaid REL data also needs to align with public health REL data.

In 2021, CMS classified Minnesota's Medicaid race and ethnicity data as "medium concern" because 10-20% were missing and out of alignment with the U.S. Census Bureau's American Community Survey (SHADAC, 2020).

A number of strategies have been suggested to improve the collection of REL data during enrollment and renewal (Lukanen & Zylla, 2020). DHS staff are considering updated wording on enrollment forms, engaging enrollment navigators about the importance of enrollees volunteering their REL data and imputing REL data from other publicly available sources. These approaches are most effective when informed and led by community. Both community members and staff acknowledge a general lack of trust in government. Building that trust will be a critical component of ethical and accurate data utilization. As noted earlier neither the U.S.-born Black community, nor any other community as captured by our current, broad racial and ethnic definitions, is monolithic. Further disaggregation will therefore lead to where within communities gaps are largest and opportunity the least. To accomplish this DHS must improve how it communicates the benefits of sharing one's demographic data and balance the protection of data with the ability to close clear and present gaps.

During the COVID-19 pandemic, the Minnesota Electronic Health Records Consortium has grown to include all of Minnesota's large health care systems and the Minneapolis Veterans Affairs Medical Center. A partnership with the Minnesota Department of Health has allowed the pooling of aggregate data from health care systems' electronic health records to provide insight into COVID-19 testing and vaccination. This has resulted in the identification of gaps in Minnesota's COVID-19 response and

allowed the state to achieve 93% REL data completion as it reports vaccination rates by race and ethnicity. Once REL data categories become disaggregated and standardized in Minnesota, collaboration between the consortium and DHS could lead to better identification of where gaps and strengths exist within the U.S.-born Black community and other historically disadvantaged communities. This can then inform investment in interventions that work as well as structure incentives around closing gaps.

For example, all DHS managed care organizations must conduct performance improvement projects to improve the care and services provided to Medicaid enrollees. Project goals must be clear, precisely defined and address a critical issue that enrollee's face. Moreover, the managed care organizations must provide objective, measurable indicators to assess the effectiveness of the interventions. These projects could be one lever to engage community about defining quality care and services. Standardized and disaggregated REL data will be important for identifying communities as well as holding DHS, the managed care organizations, counties, clinicians and others who serve Medicaid enrollees accountable.

Engaging the communities and families Medicaid serves

What is the problem?

The importance of community engagement cannot be overstated. Health inequities and the social conditions, including racism, that cause disparities have existed for centuries. Top-down policy solutions have been tried for at least a generation, and yet disparities continue to grow. Meaningful solutions must be found in consultation and partnership with communities (Interlandi, 2019). While engaging enrollees in heterogeneous groups (e.g., engaging people from multiple racial and ethnic backgrounds or people with and without disabilities at the same time) can be very helpful, culturally specific engagements are equally important. Focused engagement is more likely to draw out some of the different barriers and strengths of various groups of people as well as the common experiences that cut across racial and ethnic or other categories. This theme echoed through DHS conversations with U.S.-born Black leaders. All stressed the need for community consultation in general and for culturally specific consultation. One group expressed regret that they had not been consulted even earlier in the process of this report. All also expressed the desire to be kept in the loop as work to complete this report and implement its recommendations progress. It's important that what DHS learns is "given back to community."

This extended to how staff throughout DHS, not just those in the Medicaid program, looked to work with community directly. They wish to do so in a way that community members understand who is working with them and that it was doing so in a coordinated way.

Engaging the communities and families Medicaid serves: Opportunities and strengths identified by community

Community members expressed skepticism about "engagement," citing experience that it's been merely a check-the-box exercise in the past. They asked for more tangible work to address disparities, including sustained funding for racial equity work. One person said that she was tired of pilot programs that end when the funding ends. Addressing racial disparities was noted to require an authentic, ongoing, and

intentional commitment to community engagement. “Be real and honest about engaging people; people can pick up on that [lack of authenticity] right away, and will not be open but will close down.”

Many also stressed that engagement about Medicaid should encompass engagement about how providers treat patients and families. One person observed that Black providers experience bias from their white colleagues in the same way that Black patients do. He suggested the strategy of “being communal in how we care for each other,” building true partnerships between providers and patients. Medicaid and providers should be learning from how “we [the Black community] have conversations amongst each other.”

DHS Medicaid colleagues agreed that there had been little-to-no engagement specific to U.S.-born Black communities to date. Indeed, most agreed that there had been insufficient community engagement across the board, regardless of specific racial or ethnic focus.

Engaging the communities and families Medicaid serves: What is Medicaid doing to address this?

Some parts of the agency have sought enrollee input directly, with one example being listening sessions with U.S.-born Black Minnesotans and Black providers to hear what has been going on in response to multiple high-profile police murders of Black men in Minnesota. However, some parts of the agency have mostly relied on insight from staff members from the U.S.-born Black community.

Some of the people interviewed were familiar with DHS’ Integrated Care for High Risk Pregnancies (ICHRP) program, a grant-supported program administered by DHS in full partnership with African American community leaders and clinicians in the Twin Cities. (ICHRP also includes a parallel initiative in partnership with Native American communities and tribes.) Interviewees spoke of the need for more of these types of power-sharing arrangements to address health disparities beyond birth outcomes.

Important features of ICHRP include:

- Leadership by a community-based advisory council, whose work is facilitated and coordinated by African American consultants under a contract administered by DHS. As of this writing, the council has just become incorporated as an independent nonprofit corporation.

- Fiscal support for community infrastructure. Appropriations within the state’s base budget currently fund ICHRP. The new nonprofit corporation will soon be positioned to seek other forms of programmatic and philanthropic funding.

- Embrace of an evidence-based model specific to the psychosocial risks that are heightened among many minoritized groups. In ICHRP, this model centers on community-based, culturally specific paraprofessionals who reach out to potential clients, identify psychosocial needs and navigate to appropriate services. In some cases, health care providers refer pregnant Black people to ICHRP for the assessment and navigation; in other cases, the paraprofessionals work in reverse, helping expectant mothers and fathers who are not yet obtaining prenatal care connect to a local clinic.

- Paraprofessional services, to the extent permitted by federal and state Medicaid policy, should be covered by Medicaid directly, in order to free up programmatic funds to support the infrastructure.

DHS staff pointed to some other success stories around the agency. For example, as part of their efforts to understand and prevent child abuse and neglect, the Children and Families Services Administration uses federal funding to support an intensive training program for parents who have been involved with child protection. Parents learn about legislative and agency advisory councils and become effective members of such bodies. Similarly, staff have learned important principles, such as the importance of having more than one parent voice on any advisory body, so that parents participate on an equal footing with the many other stakeholders present.

In 2015, DHS obtained a philanthropic grant from the Bush Foundation to increase the agency's capacity to engage communities. An advisory council comprising community experts and DHS staff oversaw DHS' grant-supported activities, and approximately 25 staff members from all corners of the agency received training on facilitation methods and real-time opportunities to conduct engagement. Unfortunately, many employees who participated in the Bush-supported work have since left the agency, and there have been no initiatives of similar scale to sustain the work.

Many DHS staff expressed a strong desire to do more to engage enrollees, but felt disempowered due to insufficient resources, lack of staff and lack of training. No one questioned the value of community engagement, only the will within the agency to get it done.

Call to Action: Fund community conversations with U.S.-born Black Minnesotans on Medicaid

Community members noted that the COVID-19 pandemic has clearly demonstrated the impact of a fractured trust between state agencies and the U.S.-born Black community. A repair of this trust requires relationships be built over years and gives that community the opportunity to "start a journey of trusting larger agencies that provide resources and services." As noted above, this must be intentional. Organizations asked DHS to adopt a co-design model for health care policy and programs, creating *with* the community, not *for*. They stressed that relationship building is key, and that power should be shared. The challenge is for DHS to do it better by doing it differently. DHS employees were able to easily identify the organization's own role in perpetuating certain aspects of systemic racial health inequity in Minnesota. Concerted, reliable and consistent efforts must occur to earn back the trust of the Black community in Minnesota. Internally, DHS divisions stressed that relationship building with the community cannot be a one-time or sporadic event. To be meaningful, engagement must be dedicated, intentional and iterative.

Therefore, **DHS should integrate not just community engagement in general but longitudinal, culturally specific engagement of enrollees and their families into routine policy, budget and administrative activities.** Minnesotans who receive the services are the ones best positioned to inform what needs to be done differently in order to move the needle on health disparities. Indeed, the agency should have standing contracts with respected community partners who can engage enrollees with and for DHS. This will allow community members to share their experiences and needs and improve DHS'

ability to share what resources are currently available and how people can navigate them. Contractors are often better positioned to host these conversations, and contracting with a community facilitator makes it easier to ensure that participants can be compensated for their time and reimbursed for expenses, such as travel and child care.

What will accountability to U.S.-born Black Minnesotans look like for Medicaid in engagement?

- Creating a mechanism and expectation that community will be consulted early about current policy and budgets and future proposals that impact them.
- Developing more models of care that are community co-created and led with true power sharing.

Outcome: Sufficient funding for longitudinal, authentic community conversations.

Cultural Wellness Center CEO Elder Atum Azzahir offered the example of their "Year of Learning" approach to connecting with community members in an intentional, longitudinal process of growth both for both DHS and the community. Participating members commit to conversations that happen regularly over 12 months, receive compensation for their time and get support from community navigators and Elders who connect them to resources as needs arise. This model also centers on bi-directional learning and unlearning that places all participants in the role of both student and teacher to create transformational knowledge-sharing. A longitudinal, community-centered approach to engagement allows staff from Medicaid and other DHS programs to be in ongoing conversation. Seeing community as true partners and co-creators at all times, not just during a pandemic or to address a specific, research-identified gap, will go a long way toward repairing the trust that has been broken.

V. Capturing the moment for change

While this report prioritizes some specific Medicaid policy solutions, there were other notable observations from conversations that warrant discussion. There is a clear sense of urgency. The interviews and data that comprise this report confirm the indisputable fact that Minnesota has a staggering racial health equity problem. While Minnesota's racial health disparities have been known to those in the field for decades, the murder of George Floyd and the COVID-19 pandemic pushed the issue straight to the forefront of the public's awareness. These historic events made Minnesota's health and racial disparities international news and finally impossible to ignore. Because the general populace and their representative governments are now willing to acknowledge that racial health disparities do exist exorbitantly in Minnesota, there is an urgency for DHS to act quickly on the current momentum and commitment of many leaders and partners to substantive change.

Throughout these conversations there was a shared concern that, as in the past, DHS' current focus on health disparities is again just another flash in the pan. Organizations and staff alike have been down this road before and are all too familiar with well-intended efforts losing steam. Yet, despite the weariness, there is a willingness to try again.

All agreed that leadership, at the highest level, must play a critical role in DHS' ability to improve racial health disparities for U.S.-born Black Minnesotans; they called for prioritization, agency-wide alignment and resource allocation. Finally, and most importantly, there was a plea to keep the conversation going, because ignoring the stain of institutional racism in Minnesota has not made it go away.

VI. Conclusion

On his first full day in office, President Biden issued Executive Order 13995, establishing the Presidential COVID-19 Health Equity Task Force. He charged the task force with recommending actions against long-standing and emerging health inequities exacerbated by the COVID-19 pandemic. Ten months later, after hundreds of working sessions, extensive literature reviews, meeting with more than 100 subject-matter experts and eight public meetings, the Task Force submitted its final report (U.S. Department of Health and Human Services, 2021). The report includes 55 recommendations with five actions proposed as overarching priorities:

1. Invest in community-led solutions to address health equity.
2. Enforce a data ecosystem that promotes equity-driven decision making.
3. Increase accountability for health equity outcomes.
4. Invest in a representative health care workforce, and increase equitable access to quality health care for all.
5. Lead and coordinate implementation of the COVID-19 Health Equity Task Force's recommendations from a permanent health equity infrastructure in the White House.

Given the incredibly broad scope of the task force, it is notable that all five of the proposed priorities are reflected in some way in this report's Calls to Action to build racial equity into the walls of Medicaid for U.S.-born Black Minnesotans. This gives further credence to the belief that choosing to focus on a historically under-resourced community is vital to authentically addressing racial health inequities. One example of how this approach has taken hold throughout Minnesota is the Minnesota Business Coalition for Racial Equity, which comprises leaders from 80 organizations including most of Minnesota's Fortune 500 companies. Their purpose: "coming together to build an equitable, inclusive and prosperous state with and for Black residents." This is not a zero sum tactic; it instead improves policies and programs for all, getting the state closer to an overall goal where, "all Minnesotans are provided the opportunity to lead healthy, fulfilled lives," as detailed in Governor Tim Walz' very first executive order: 19-01 Establishing the One Minnesota Council on Diversity, Inclusion and Equity.

The Calls to Action detailed and justified in this report serve as a guide to prioritize actions to improve racial equity for U.S.-born Black Minnesotans on Medicaid. They also overlap with the needs of other historically under-resourced communities. The iterative process established in developing this report, its policy recommendations and the subsequent accountability for action also aim to set the expectation for other work within DHS. Next steps must include reports on building racial and health equity into Medicaid for Native and Indigenous Minnesotans, Hispanic/Latino Minnesotans, Asian-Pacific Islander Minnesotans, immigrants/new Minnesotans, Minnesotans who are LGBTQ+, Minnesotans living with disabilities, unhoused Minnesotans and incarcerated Minnesotans.

What may surprise readers of this report most is that these are not revolutionary ideas and approaches to the work of population health. More than 100 years ago, sociologist and civil rights activist W.E.B. Du Bois was pointing out the impact of structural racism and how social drivers of health impacted the opportunity of Black Americans. The solutions he proposed then echo throughout this report. In 1906, he wrote in *The Health and Physique of the American Negro*, "The Conference recommends the

formation of local health leagues among colored people for the dissemination of better knowledge of sanitation and preventive medicine. The general organizations throughout the country for bettering health ought to make special effort to reach the colored people. The health of the whole country depends in no little degree upon the health of Negroes."

Some 116 years later, Americans are still striving to create a system that has racial equity built into the walls instead of being simply seen as optional wallpaper. To meet this moment, it's time to heed another piece of advice Du Bois shared, this time in his book, *The Souls of Black Folk*:

"Now is the accepted time, not tomorrow, not some more convenient season. It is today that our best work can be done and not some future day or future year."

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Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic

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KEY POINTS

- Research shows that disruptions in Medicaid coverage are common and often lead to periods of uninsurance, delayed care, and less preventive care for beneficiaries.
- Studies indicate that beneficiaries moving in and out of Medicaid coverage (sometimes called "churning") results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services.
- One study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs ($371/month in 2021 after adjusting for inflation) than those with six months of coverage ($583/month) or only three months of coverage ($799/month).
- The postpartum period is a particularly high-risk time for churning as studies show that 55 percent of women with Medicaid coverage at delivery experience a coverage gap in the following six months compared to 35 percent of women with private insurance. This is of particular concern for pregnant women of color, who experience large disparities in maternal mortality before and after childbirth and account for a larger proportion of Medicaid beneficiaries compared to the overall U.S. population.
- The Families First Coronavirus Recovery Act has helped reduce Medicaid churning, temporarily, through its continuous enrollment requirements for enhanced funding for the duration of the COVID-19 Public Health Emergency.
- State decisions, such as adopting the Affordable Care Act's Medicaid expansion to adults and the extended continuous eligibility option for postpartum coverage starting in April 2022 under the American Rescue Plan, can play an important role in reducing rates of churning.

INTRODUCTION

Coverage disruptions and coverage loss in Medicaid, often referred to as "churning," frequently occur among Medicaid beneficiaries. Difficulties navigating state renewal and redetermination procedures – even among individuals who are still eligible – as well as income fluctuations and changing family circumstances can lead to the loss of coverage. Churning occurs when people lose Medicaid and then re-enroll within a short period of time. Gaps in health coverage occur because many people experiencing churning do not transition successfully to Marketplace or employer-based coverage for the months in which they were not enrolled in Medicaid.[1] The Families First Coronavirus Response Act (FFCRA) maintenance of eligibility (MOE) and continuous enrollment requirements have temporarily halted most Medicaid churning. Under the continuous enrollment provision in FFCRA, states that accept the law's temporary increase in federal Medicaid funding are prohibited from

terminating most beneficiary enrollment for the duration of the public health emergency with limited exceptions.[i] This Issue Brief reviews evidence on churning among the Medicaid population and different policy options for states and the federal government to reduce churning, including continuous eligibility, Medicaid expansion to adults, express lane eligibility, presumptive eligibility, multimarket plans, and limiting premiums and cost-sharing.

PREVALENCE AND CAUSES OF MEDICAID CHURN

Prevalence of Medicaid Churn

The typical Medicaid beneficiary is covered for less than 10 months out of the year. Length of coverage is slightly higher for beneficiaries with disabilities (10.8 months) and seniors (10.3 months), and lower for non-elderly, non-disabled adults (about 8.6 months).[2,3] One study found nearly 25 percent of Medicaid beneficiaries changed coverage within one year and most of these beneficiaries (55 percent) also experienced a gap in coverage.[4] Churning rates are somewhat lower in children, in part due to higher income eligibility levels and policies designed to improve continuity of coverage in this population; however, not all states have taken advantage of federal policy options that could reduce churning among children further.[5,6] The postpartum period is a particularly high-risk time for churning, as studies show that 55 percent of women with Medicaid coverage at delivery experience a coverage gap in the following six months, compared to 35 percent of women with private insurance. Pregnant women are also more likely to experience a coverage gap after delivery if they do not speak English at home or have a family income between 100–185 percent of the federal poverty level (FPL).[7]

State Eligibility and Renewal Policies

Policies that affect individuals' ability to maintain Medicaid coverage vary by state. As of January 2020, 23 states have adopted the Medicaid state option to provide a full 12 months of continuous eligibility for children.[8] In the 36 states that have implemented the Medicaid adult group expansion, the median income eligibility limit for all non-elderly adults is 138 percent of the FPL. In non-expansion states, the median income eligibility limit for parents is 41 percent of FPL, and other adults without disabilities are generally ineligible for Medicaid regardless of their income level with the exception of a few state demonstrations (e.g., Georgia, South Carolina and Wisconsin). More restrictive eligibility criteria mean that modest and temporary increases in monthly income can lead to loss of Medicaid eligibility, even among very low-income beneficiaries.

States are required to review eligibility only once every 12 months for beneficiaries whose eligibility is based on Modified Adjusted Gross Income (MAGI) methodologies and at least once every 12 months for non-MAGI beneficiaries. States must first attempt to renew eligibility for all beneficiaries based on available information prior to contacting the individuals. The state must provide MAGI enrollees, for whom the state cannot renew eligibility based on available information, at least 30 days to return their renewal form and any required information. Between yearly renewals, enrollees must timely report changes that may affect eligibility (e.g., income changes) and states can conduct periodic data checks to identify potential changes. In 2020, 30 states reported periodic data checks however, as of March 2021, five states have discontinued periodic data checks during the public health emergency. If the state has information indicating an enrollee has experienced a change, it must request additional information from the individual. Some states provide as few as 10 days for enrollees to respond, raising concerns about the limited time allowed to gather appropriate documentation, which means eligible individuals may lose coverage if they do not respond to state information requests within the required timeframe.

[i] Exceptions include when a beneficiary's state residence changes or voluntary disenrollment from the program.

In some cases, state compliance with eligibility redetermination policies can result in significant coverage declines. In 2018, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) decreased by over 1.5 million enrollees, and there is evidence that state enrollment policies were a driving factor. For example, the three states with the largest percentage drops in enrollment - Tennessee, Arkansas, and Missouri - required the use of phone or mail for eligibility renewals, which can be fraught with problems. Beneficiaries may change addresses or miss mailings, and phone applications typically involve long wait times and problematic voice interfaces.[9] In Missouri, enrollment dropped by 70,000 in one year, including 55,000 children, mostly due to families not returning a mailed renewal form created by the state's new automated eligibility system. In Tennessee, after the state started conducting manual eligibility redeterminations in 2016 using a complex renewal packet, there was a nearly 10 percent decrease in Medicaid enrollment (over 148,000 individuals) between 2017 and 2018. Tennessee was under an approved mitigation plan at this time and had not conducted renewals for several years. While some disenrolled individuals were likely not eligible and needed to be terminated, eligible people were also disenrolled during this process. [10]

There is generally less Medicaid churning among children compared to other Medicaid populations, as noted earlier. In states with more restrictive redetermination policies, however, churning can be high among children as well. For example, about 90 percent of the coverage loss in Texas between December 2017 and 2018 was among children (over 144,000 enrollees), similar to Missouri's experience in 2018. Texas conducts multiple checks of state income data throughout the year and sends routine mailings to parents and caregivers to verify income. These requests require a response within 10 days or children are at risk of coverage loss. This restrictive time period for verifying income has resulted in Medicaid coverage loss for children; for instance, the Texas Children's Health Coverage Coalition reported that missing the 10-day window for a response accounts for over 90 percent of the losses in coverage.[11]

Income Fluctuations

Research shows that people with lower incomes are more likely to experience frequent income fluctuations compared to higher income populations. One study of low and moderate-income households found that they experienced an average of 2.5 months each year in which income fell by more than 25 percent, and 2.6 months in which income increased by 25 percent.[12] This is far greater than income fluctuations seen among higher earners. For example, a 2014-2015 survey of 5,661 individuals about family finances found 53 percent of low-income households (less than $25,000 per year) experienced significant income changes (i.e., changes greater than 25 percent) compared to 27 percent of upper income households ($85,000 or more per year).[13]

Moreover, people of color and those with less education experience greater income volatility.[14] In the 2014-2015 survey, 38 percent of Black households and 45 percent of Hispanic households experienced income volatility, compared to 32 percent of white households. In that same year, 40 percent of households with a high school diploma or less experienced income volatility compared to 28 percent of households with a bachelor's degree. These income changes in turn can make individuals temporarily ineligible for Medicaid for short periods of time before their income changes again and they reestablish eligibility, requiring them to re-enroll in coverage. Income fluctuations have become even more common during the COVID-19 pandemic.[15]

IMPACTS OF MEDICAID CHURNING

Continuity of Care and Health Outcomes

People who experience churning or coverage disruptions are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits. One study found that unstable Medicaid coverage increased emergency department use, office visits, and hospitalizations between 10 percent and 36 percent and decreased use of prescription medications by 19 percent, compared to individuals with consistent Medicaid coverage.[16] Children with interruptions in coverage also are more likely to have delayed care, unmet medical needs, and unfilled prescriptions.[17] Lack of coverage affects access to

care, and even short periods of uninsurance affect access. One study found individuals lacking coverage for 1-5 months had worse access to care compared with those covered for all 12 months. [18]

While disruptions in coverage often lead to periods of uninsurance, transitioning between health plans can also result in impeded access to care due to differing provider networks, benefits, and drug formularies. One study examining low-income adults whose insurance status changed but did not have a gap in coverage found that 13 percent had to change at least one provider, 22 percent skipped doses or stopped taking prescription medications, and 29 percent reported an overall harmful effect on the quality of their health care.[19] An analysis of one health insurance carrier in 2019 found one-third of Medicaid expansion enrollees changed coverage type (i.e., fee-for-service, Medicaid managed care or individual market plans) or disenrolled within one year, and one-third of those who left re-enrolled with the same payer within one year.[20] Moreover, a 2015 survey of low-income adults in Arkansas, Kentucky, and Texas found one in four respondents changed health coverage at least once. Over half of respondents who changed insurance plans experienced a gap in coverage, and 47 percent reported a decline in their overall health.[21]

Administrative and Beneficiary Costs

Churning increases administrative costs and is associated with more avoidable and less predictable expenditures on medical care by beneficiaries cycling in and out of Medicaid. A 2015 analysis estimated the administrative cost of one person's churning, including disenrolling and reenrolling, to cost between $400 and $600.[22] Providers and Medicaid managed care organizations are also burdened by churning as it limits the ability to provide effective care and achieve managed care quality requirements, and increases administrative costs, such as the costs of processing new applications.[23]

While churning lowers Medicaid medical expenditures by creating smaller monthly patient caseloads, it can lead to higher monthly per member costs. Some studies suggest people who churn in and out of coverage have higher Medicaid monthly health care costs due to pent-up demand for health care services after a period of ineligibility.[24] One study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs ($371/month enrolled in 2021 after adjusting for inflation) than those with six months of coverage ($583/month enrolled) or only three months of coverage ($799/month enrolled).[25] Cost impacts may be especially pronounced for beneficiaries with chronic conditions. For example, Medicaid beneficiaries with diabetes with a lapse in coverage had per member per month costs that were $239 greater during the three months after reenrollment than in the three months prior to the coverage lapse.[26] Thus, by reducing churn, states spend more on Medicaid overall, but do so in a more efficient manner that improves care for beneficiaries: continuous coverage leads to more predictability in monthly caseload expenditures, lower average monthly spending, lower enrollee spending on administrative costs, and better overall continuity of care for beneficiaries.

FAMILIES FIRST CORONAVIRUS RESPONSE ACT

Maintenance of Eligibility and Continuous Enrollment

FFCRA provides a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) for certain Medicaid spending to support states and promote coverage stability during the pandemic. To receive the enhanced FMAP, states must meet certain maintenance of eligibility (MOE) requirements, including ensuring continuous enrollment for current enrollees through the end of the public health emergency.[27] Following enrollment declines from 2017 through 2019, preliminary data show that total Medicaid and CHIP enrollment grew to 77.3 million in September 2020, an increase of almost 6.7 million (9.4 percent) from actual enrollment in February.[28] Medicaid enrollment is increasing at a much greater rate than applications. Thus, enrollment increases are likely being driven by existing enrollees remaining eligible due to the FFCRA MOE requirements.[29]

Upon conclusion of the public health emergency, normal state Medicaid operations will resume, including eligibility redetermination. This will represent a substantial and unprecedented undertaking for Medicaid programs, with the potential for significant coverage losses and disruptions. The end of the public health emergency may be a natural time to consider making Medicaid coverage more stable and less administratively burdensome using some of the policies described in this Issue Brief, including the American Rescue Plan's (ARP) new option for continuous eligibility for women after childbirth.

POLICY OPTIONS TO ADDRESS CHURNING

ACA Medicaid Expansion to Adults

Research has found that part of the ACA's reduction in the uninsured rate can be attributed to increased retention of Medicaid enrollees, and states that have adopted the Medicaid adult group expansion have lower rates of churning in and out of Medicaid than non-expansion states.[30] Among Medicaid beneficiaries aged 19–64, disruption in coverage decreased by 4.3 percentage points in states that expanded Medicaid compared to states that have not expanded, amounting to approximately half a million beneficiaries maintaining their coverage each year. Among pregnant women, nearly half of women in Medicaid non-expansion states experienced an insurance disruption from preconception to postpartum between 2015-2017, compared to one-third of women in Medicaid expansion states.[31,32] Further, there was a greater decrease in disruptions of coverage among people of color compared to white individuals in expansion states compared to non-expansion states. Researchers have highlighted three likely ways Medicaid expansion has reduced churning:

1. The higher income threshold of 138 percent of FPL accommodated larger monthly fluctuations in income without loss of eligibility;
2. The standardized upper eligibility threshold simplified requirements across states; and
3. Expansion states generally increased their outreach efforts and enrollment assistance for Medicaid.[33]

Moreover, expanding Medicaid to more parents also benefits their children. Family coverage has been shown to play an important role in whether eligible children renew their coverage in Medicaid or CHIP,[34] and research demonstrates that states that have expanded Medicaid coverage for low-income parents have experienced significantly greater gains in enrollment among eligible children as well.[35]

The ARP encourages non-expansion states to take up Medicaid expansion by providing an additional temporary fiscal incentive. Under the ARP, states receive the ACA 90% FMAP for the adult group expansion population costs. In addition, states that do not have expansion in place when the ARP was enacted are eligible for a 5 percentage-point increase in the state's traditional FMAP rate for two years (2021-2022) if they implement the expansion for the adult group. The traditional FMAP applies to most services for non-expansion groups, including children, non-expansion adults, seniors, and people with disabilities.[36] In addition to receiving the ARP's temporary FMAP increase, states will also receive the 90 percent ACA FMAP for the expansion population costs.

Continuous Coverage

Continuous eligibility policies allow Medicaid beneficiaries to maintain continuous coverage even if they experience a change in circumstances (e.g., income) during the continuous eligibility period. One 2015 analysis found Medicaid churning within a calendar year would decrease by 30 percent with 12 months of continuous eligibility. This translates to 20 percent (5 million) more beneficiaries covered all year, increasing the average monthly caseload by 17 percent (6.8 million).[37]

States have been able to allow children to stay enrolled in Medicaid and/or CHIP for up to 12 months regardless of changes in their families' circumstances under the "continuous eligibility" option since 1997. As of January 2020, 23 states provide 12-month continuous eligibility for children in Medicaid and 25 states do so for children enrolled in CHIP.[38] Children living in these states are much less likely to be uninsured (7.8 percent

vs. 11.7 percent) and to have had a gap in coverage in the previous 12 months (11 percent vs. 15.9 percent) compared to children in states without continuous eligibility.[39]

While not the same as continuous eligibility (which guarantees ongoing coverage even with a change in circumstance), extending the time period for eligibility renewals and redeterminations can also impact continuity in coverage. In the first two years after California extended its Medicaid redetermination period for children from 3 months to 12 months, the percentage of children who had continuous coverage increased from 49 percent to 62 percent, and there was a reduction in hospitalizations related to ambulatory care-sensitive conditions, reducing hospital spending by $17 million.[40]

Two states, Montana and New York, have approved 1115 demonstration projects that provide continuous eligibility for adult group beneficiaries. The Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended that Congress create a state plan continuous eligibility option for adults in Medicaid so states could adopt it without a waiver, concluding that the option would reduce "churning and the negative health effects that may result."[41] In evaluating the New York and Montana demonstrations that extended continuous eligibility to adults, the Centers for Medicare & Medicaid Services (CMS) estimated that increased enrollment due to the policy would raise costs for the Medicaid expansion population by 2 to 3 percent, which is similar to cost increases seen in states when extending continuous coverage to children.[42]

The ARP established a new state plan option for states to extend postpartum coverage in Medicaid and CHIP to women for 12 months and provide continuous eligibility through the extended postpartum period. Starting in April 2022, women covered under this option will receive comprehensive Medicaid benefits, not just pregnancy-related benefits, and will have continuous eligibility for the extended postpartum coverage period regardless of change in circumstances for the 12-month period. This option will be available to states for five years, granting states the opportunity to extend postpartum coverage without a section 1115 demonstration.[43] Medicaid covers about 42 percent of all births in the U.S., so extending Medicaid coverage in the postpartum period may increase rates of health insurance coverage during this period. This new option also may help address the U.S.'s high rates of maternal mortality and severe morbidity, which include deaths up to one year postpartum, particularly among Black and American Indian and Alaska Native (AI/AN) mothers. Overall, Black and AI/AN women are 2 to 3 times more likely to die of pregnancy-related causes than white women. These disparities exist across all age groups but increase with maternal age. For example, in the under 20 age group, Black women have a pregnancy-related mortality rate 1.5 times higher than white women, but in the 30-34 age group, Black women have a mortality rate 4 times higher.[44] While maternal mortality rates generally decrease with education attainment, racial and ethnic disparities in the rates widen. College-educated Black women have maternal mortality rates over 5 times higher than college-educated white women and over 1.6 times higher than white women without a high school diploma. Similarly, maternal morbidity rates are almost twice as high among Black and AI/AN women than among white women.[45] Black and AI/AN individuals also account for a larger proportion of Medicaid beneficiaries compared to the overall U.S. population, raising the importance of Medicaid coverage policies in addressing racial and ethnic disparities in maternal health outcomes. [46]

All state Medicaid programs must provide pregnancy-related coverage under the state plan regardless of changes in income, through the end of the month that a 60-day postpartum period ends, at which point women who qualify for Medicaid on the basis of pregnancy risk becoming uninsured or experiencing disruptions in coverage. Women in states that have not expanded Medicaid to the adult group are particularly vulnerable as states' income eligibility levels for parents are often much lower than for pregnancy.[47] Some states have sought to extend Medicaid's postpartum period through section 1115 demonstration projects. To date, CMS has approved targeted extensions of postpartum coverage in the Georgia Planning for Healthy Babies demonstration and the South Carolina Palmetto Pathways to Independence demonstration, as well as in a number of states that have used section 1115 authority to extend the duration of Medicaid eligibility for

pregnant women beyond the 60-day postpartum period to provide a benefit of family planning and related preventive women's health services. In addition, five states (Georgia, Indiana, Missouri, New Jersey, and Texas) have pending section 1115 requests for postpartum coverage extensions from six months up to 12 months, including the existing 60-day postpartum period.[ii] Four of these states are seeking to provide full Medicaid benefits beyond the standard 60-day postpartum period. One state seeks to provide targeted benefits to address major health conditions recognized as contributing to maternal morbidity and mortality. These states are also seeking to align the continuous eligibility period provided to pregnant women with the extended postpartum period to maintain enrollment regardless of changes in income. In addition, through a state funded program, California has extended coverage for up to 12 months for eligible individuals diagnosed with a maternal mental health condition, such as postpartum depression, through the state's Provisional Postpartum Care Extension.[48]

Express Lane Eligibility and Presumptive Eligibility

Express Lane Eligibility (ELE) allows states to use eligibility findings from other public programs to verify Medicaid and CHIP eligibility for children, eliminating duplication of administrative efforts and easing the burden on families from having to provide the same information to multiple agencies.[49] ELE agencies may include: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Women, Infants, and Children (WIC).[50] ELE may be adopted by states through a state plan amendment, which 13 states have done for children in Medicaid and/or CHIP. These states have reported reduced administrative burden and cost savings.[51]

Presumptive Eligibility (PE) is a Medicaid state option to allow specific "qualified entities," such as health care providers, hospitals, schools, government agencies and community-based organizations, to screen pregnant women, children, parents and other non-elderly adults for Medicaid eligibility and temporarily enroll them. These policies allow individuals determined presumptively eligible to secure covered health care services without delay while they complete the regular application process for ongoing coverage. As of January 2020, 30 states had implemented PE policies for pregnant women, 19 states had PE for children, 9 states had PE for parents, and 8 states provided PE for other non-elderly adults.[52] PE can be used in conjunction with targeted efforts at the community level to find and enroll the hardest to-reach, uninsured children. It also simplifies the enrollment process through direct, one-on-one assistance.[53]

ELE and PE policies support President Biden's whole-of-government equity agenda.[54] A central component of this agenda is identifying and addressing barriers that underserved communities and individuals may face related to enrollment in and access to benefits and services in federal programs.

Shared Plans between Medicaid and Marketplace

Having the same insurers in both Medicaid and the Marketplace can help keep beneficiaries in more consistent coverage, with similar provider networks and formularies, even if they have to transition from Medicaid to Marketplace or vice versa.[55] The ability for issuers to participate across multiple public financing arrangements and provide stable provider networks is essential to achieving continuity of care.[56] Medicaid managed care companies may be suited to playing a role in this area. In 2021, 47 percent of all parent insurers offered a Marketplace plan and Medicaid plan in the same state, and there were 36 states with at least one of these parent insurers.[57] However, these multimarket plans – while reducing the potential disruption from churning – only address churning between Medicaid and Marketplace coverage (but not employer coverage) and do not eliminate the underlying disruption in coverage, unlike some of the other policies discussed earlier.

[ii] Illinois received approval on April 12, 2021 for a demonstration project extending postpartum coverage for 12 months.

Limiting Premiums and Cost-Sharing

Using section 1115 authorities, states have implemented premiums and cost sharing in Medicaid with the stated goals of promoting personal responsibility, preparing beneficiaries to transition to commercial and private insurance, and supporting consumers in making value-conscious health decisions. However, research has shown premiums act as a barrier to accessing care and maintaining coverage, including increasing disenrollment and shortening length of enrollment in Medicaid and CHIP among adults and children.[58] [59]

CONCLUSION

Churning between sources of health coverage, including periods without health insurance, occurs frequently in the Medicaid and CHIP population and is associated with adverse effects on health care access. Continuous coverage or allowing beneficiaries to maintain Medicaid coverage for a set period of time irrespective of changes in their circumstances, helps prevents disruptions in health care for beneficiaries and provides states more predictable and efficient spending. While the FFCRA MOE and continuous enrollment requirements have temporarily halted most Medicaid churning, the pandemic's health and economic toll has increased the importance of the Medicaid program for beneficiaries and providers, and there is the potential for significant coverage disruptions and losses of health insurance coverage when the public health emergency ends. As states prepare to return to normal operations, policymakers should consider a range of policies that promote more stable coverage in the Medicaid population, including Medicaid expansion and continuous coverage options such as those created by the ARP.

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Florida

SUMMARY

According to CCF's child health coverage report, the number of uninsured children stabilized in 2022 due in large part to the continuous coverage protection that prevented children from being disenrolled from Medicaid during the COVID-19 public health emergency. However, the continuous coverage protection has now been lifted and children are losing coverage as Florida redetermines eligibility for everyone enrolled. Nationwide, an estimated three out of four children losing coverage during this period will still be eligible for Medicaid or CHIP but could fall through the cracks due to procedural issues.

Health coverage is important for children because it improves access to pediatrician-recommended care and services that support healthy development. When children get the health care they need, they are more likely to succeed in school, graduate from high school and attend college, earn higher wages, and grow up into healthy adults. Scroll down for an in-depth look at child health care trends across Florida.

Coverage Trends

Health care coverage is important for children because it improves access to pediatrician-recommended care and services that support healthy development. When children get the health care they need, they are more likely to succeed in school, graduate from high school and attend college, earn higher wages, and grow up into healthy adults. Scroll down for an in-depth look at child health care trends in this state.

Uninsured Florida

7.4%

of **children** do not have health insurance

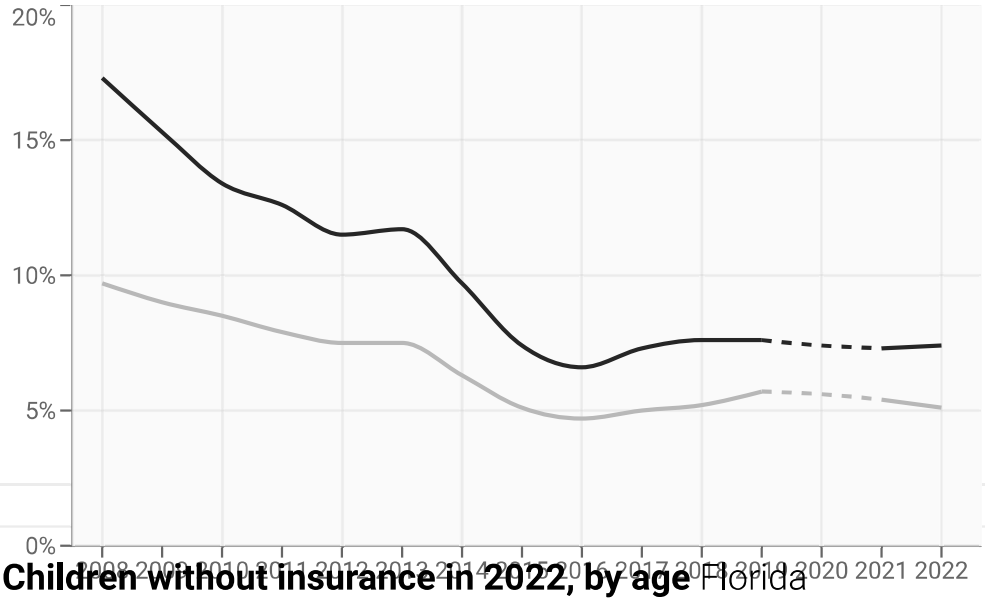
Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Health Insurance Historical Table HIC-5. Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2022. Because of data quality issues related to the pandemic, the Census Bureau did not publish standard, comparable 1-year estimates for 2020; CCF excludes 2020 ACS data from all of its analyses.

Rank among states 2022

46/51

When children are uninsured, they are more likely to have unmet health needs and lack a usual source of care, diminishing their chances to grow into healthy and productive adults.

Rate of uninsured children under 19.



Children without insurance in 2022, by age Florida

National State No Data

▲ Significant years

Age

6-18 years old

8.1%

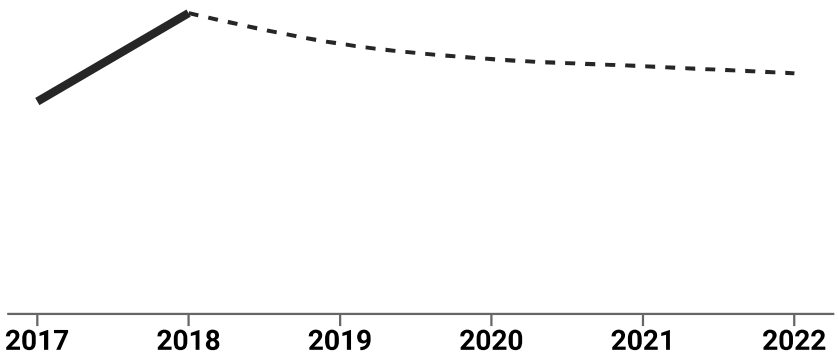
Under 6

5.8%

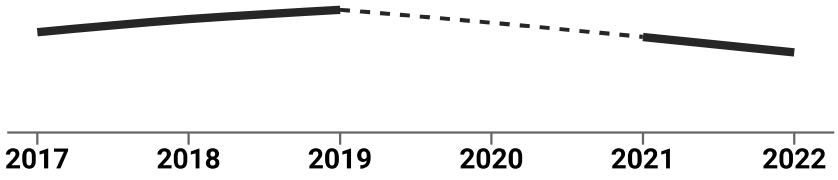
Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2022 American Community Survey (ACS), Table S2701: Selected Characteristics of Health Insurance Coverage in the United States.

Children without insurance, by Race Florida

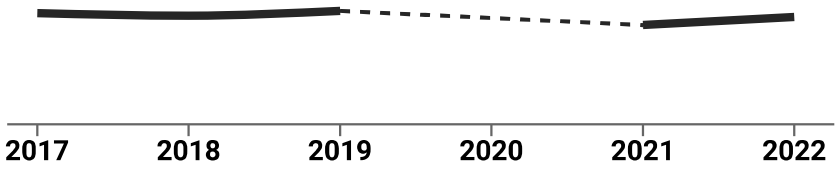
American Indian/Alaskan Native



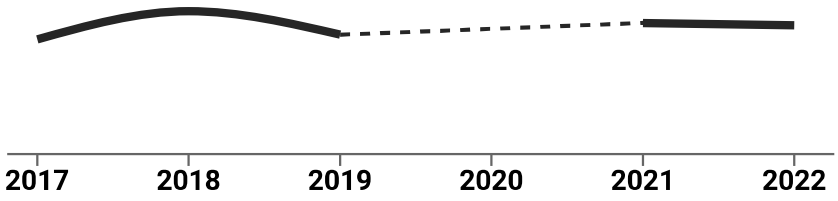
Asian/Native Hawaiian/Pacific Islander



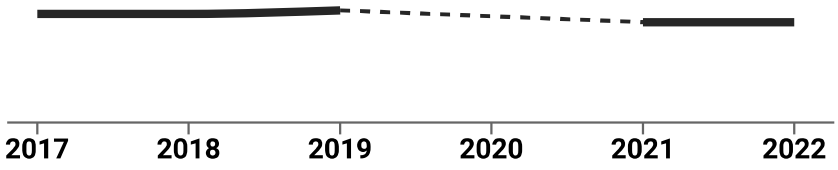
Black/African American



Other/Multiracial



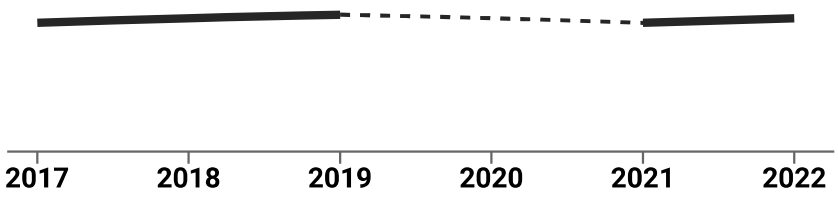
White



Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2022 American Community Survey (ACS), Tables C27001A-I: Health Insurance Coverage Status by Age. Triangles indicate change is statistically significant at the 90% confidence level relative to the prior year indicated. Blank data indicates that an estimate is not available due to insufficient sample. In 2020, the Census Bureau made changes to the ACS race and ethnicity questions, which may affect health coverage comparisons related to race and ethnicity. As a result, the Census Bureau recommends caution in comparing 2019-2021 ACS estimates related to race and caution in comparing both 2019-2021 and 2021-2022 ACS estimates related to ethnicity.

Children without insurance, by Ethnicity Florida

Hispanic/Latino

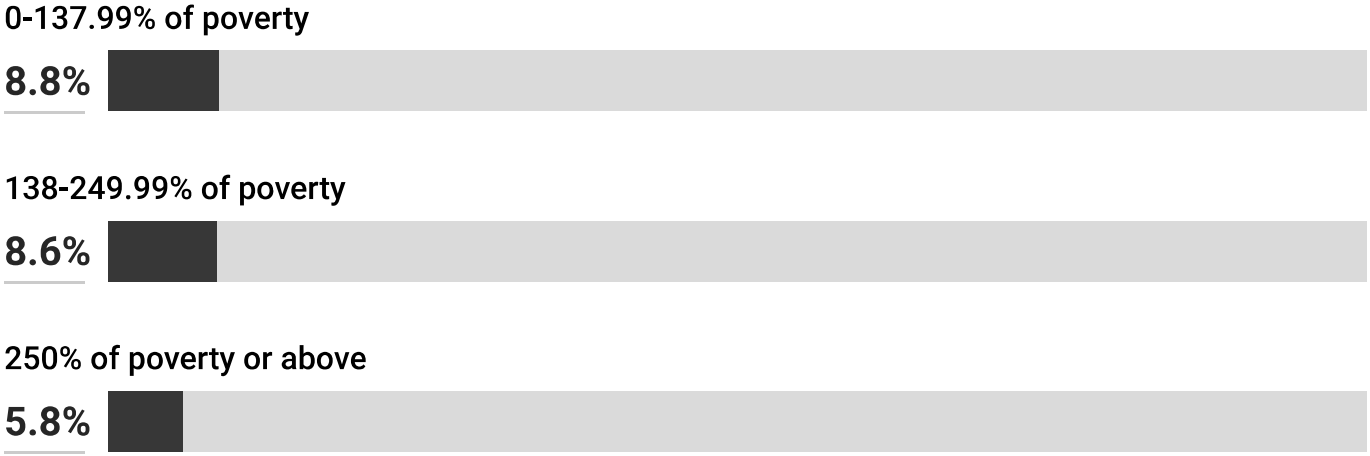


Not Hispanic/Latino

Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2022 American Community Survey (ACS), Tables C27001A-I: Health Insurance Coverage Status by Age. Triangles indicate change is statistically significant at the 90% confidence level relative to the prior year indicated. Blank data indicates that an estimate is not available due to insufficient sample. In 2020, the Census Bureau made changes to the ACS race and ethnicity questions, which may affect health coverage comparisons related to race and ethnicity. As a result, the Census Bureau recommends caution in comparing 2019-2021 ACS estimates related to race and caution in comparing both 2019-2021 and 2021-2022 ACS estimates related to ethnicity.

Children without insurance in 2022, by poverty threshold Florida

Child Uninsured Rate by Poverty Threshold: Income by Percentage/Dollars in Florida



Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2022 American Community Survey (ACS), Table B27016: Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age. Census Poverty Thresholds differ from the Poverty Guidelines (commonly known as the Federal Poverty Level or FPL) determined by the U.S. Department of Health and Human Services (HHS), and may differ considerably for the separate FPLs that HHS determines for Alaska and Hawaii. Dollar amounts shown reflect 2024 Poverty Guidelines.

How are children covered? Florida

Sources of Coverage for Children in Florida

Source: KFF, "Health Insurance Coverage of Children 0-18," available at https://www.kff.org/other/state-indicator/children-0-18/.

Medicaid/CHIP

40.4%

Other Public

2.3%

Uninsured

7.4%

Participation in Medicaid/CHIP Florida

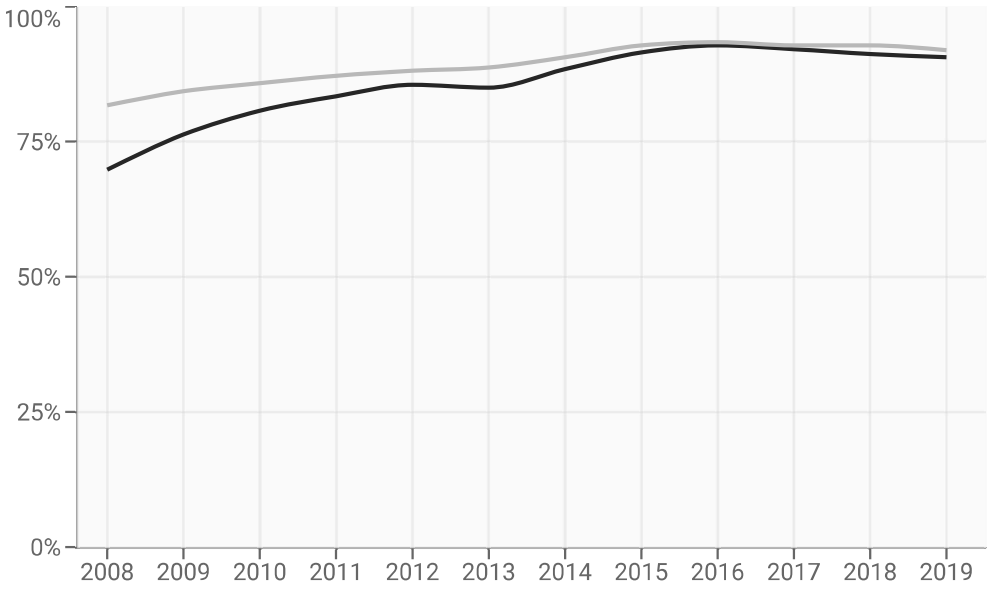
90.6%

of all eligible children participate in Medicaid/CHIP

Source: Haley, J., et al., "Uninsurance Rose among Children and Parents in 2019: National and State Patterns," (Washington D.C.: The Urban Institute, July 2021); and Haley, J., et al., "Progress in Children's Coverage Continued to Stall Out in 2018: Trends in Children's Uninsurance and Medicaid/CHIP Participation," (Washington D.C.: The Urban Institute, October 2020).

Many children who are eligible for Medicaid/CHIP may not be enrolled due to a lack of public outreach or administrative barriers. The child participation rates show the percentage of eligible children who are enrolled in Medicaid/CHIP.

Children's participation rate in Medicaid/CHIP over the last 10 years.



Who Qualifies? Florida

Eligibility: Upper income threshold for Medicaid/CHIP

Children under 19 (family of three)

US Median: 255%

215%

Parents (family of three)

US Median: 138%

28%

Pregnant women (family of three)

US Median: 207%

196%

Single adults without dependent children

US Median: 138%

0%

Source: Brooks, T. et al., "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision," (Georgetown University Center for Children and Families and Kaiser Family Foundation, March 2023), available at https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/. Dollar amounts shown reflect 2024 Poverty Guidelines determined by the U.S. Department of Health and Human Services (HHS).

Policy Options

Medicaid is a primary source of health insurance for children, providing guaranteed coverage, pediatrician recommended services, and premium and cost-sharing protections. Each state has the flexibility to design its program within federal guidelines as a condition of federal matching funds. The Children's Health Insurance Program (CHIP) builds on Medicaid to cover children in working families who are not eligible for Medicaid but cannot afford private coverage. Each state designs its program within federal parameters (and can expand Medicaid and/or establish a separate state program) but all CHIP programs provide affordable coverage with pediatric-appropriate benefits and networks. Within Medicaid and CHIP, states have several policy options available to help remove barriers to health coverage and improve children's enrollment and retention. Scroll down to see which policy options this state is leveraging to improve health coverage.

Policy options Florida

12-Month Continuous Child Eligibility (Medicaid) All states are required to provide 12 months of continuous eligibility starting January 1, 2024.	✓
12-Month Continuous Child Eligibility (CHIP) All states are required to provide 12 months of continuous eligibility starting January 1, 2024.	✓
No CHIP Waiting Period	2 months
Child Eligibility for Lawfully Residing Immigrants (Medicaid)	✓
Child Eligibility for Lawfully Residing Immigrants (CHIP)	✓
Presumptive Eligibility for Children's Coverage (Medicaid)	✗

Presumptive Eligibility for Children's Coverage (CHIP)	✗
Allow Schools to be Reimbursed for Medicaid Services without IEP	✓
Medicaid Expansion	✗
Eligibility for Lawfully Residing Immigrants during Pregnancy (Medicaid)	✗
Eligibility for Lawfully Residing Immigrants during Pregnancy (CHIP)	N/A
Eligibility for From-Conception-to-End-of-Pregnancy Option in CHIP Formerly called "Unborn Child Option"	✗
Postpartum Coverage Section 1115 Demonstration	12 months
Presumptive Eligibility for Pregnancy Coverage (Medicaid)	✓
Presumptive Eligibility for Pregnancy Coverage (CHIP)	N/A

Source: Georgetown University Center for Children and Families and Kaiser Family Foundation, “Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies: Findings from a 50-State Survey.” This survey is conducted annually; these data draw from surveys for 2020-2023.

Quality of Care

Medicaid has been successful in providing children with a usual source of care while significantly reducing unmet or delayed needs for medical care, dental care, and prescription drugs due to costs. Focus on improving the quality of care for children covered by Medicaid/CHIP is critical to eliminating health disparities and further boosting the broader, long-term impacts of public coverage on children as evidenced by studies showing that Medicaid leads to better health, higher educational achievement, and greater economic success later in life. As Medicaid increasingly turns to private managed care as the primary delivery system, measuring quality is a critical check on plan performance in providing required services and benefits. The Child Core Set, a set of standardized, evidence-based measures to assess the quality of care and health outcomes for children covered by Medicaid/CHIP, are an important tool for measuring how states are performing. Reporting is currently voluntary for states, but reporting of these measures will be mandatory in 2024. Scroll down to learn more about how this state is performing on health care quality measures.

Quality Measures Florida

Florida reporting on Behavioral Health Care, 2020

Behavioral Health Care

FL Rate	Worst	Median	Best

Follow-Up After Hospitalization for Mental Illness: Ages 6 - 17 (Follow Up Visit Within 7 Days of Discharge)

★★★★

37.9%

Follow-Up After Hospitalization for Mental Illness: Ages 6 - 17 (Follow Up Visit Within 30 Days of Discharge)

★★★★

61.8%

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12 (1 Follow-Up Visit During the 30 Day Initiation Phase)

★★★★

45.5%

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12 (At Least 2 Follow-Up Visits During the 9 Month Continuation and Maintenance Phase Following Initiation Phase)

★★★★

57.3%

Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 (Blood Glucose Testing)

★★★★

53.3%

Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 (Cholesterol Testing)

★★★★

40.1%

Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 (Blood Glucose and Cholesterol Testing)

★★★★

37.4%

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17

★★★★

60.5%

Florida reporting on Care of Acute and Chronic Conditions, 2020

Care of Acute and Chronic Conditions

FL Rate	Worst	Median	Best

Asthma Medication Ratio: Ages 5 to 11

★★★★

82.8%

Asthma Medication Ratio: Ages 12 to 18

★★★★

74.3%

Asthma Medication Ratio: Ages 5 to 18

★★★★

79.5%

Ambulatory Care: Emergency Department (ED) Visits: Ages 0 to 19

★★★★

55.5%

Florida reporting on Dental and Oral Health Services, 2020

Dental and Oral Health Services

FL Rate	Worst	Median	Best

Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk

★★★★

31.8%

Percentage of Eligibles Who Received Preventive Dental Services: Ages 1 to 20

★★★★

33.2%

Maternal and Perinatal Health

FL Rate	Worst	Median	Best

Contraceptive Care: All Women Ages 15 to 20 (Most Effective or Moderately Effective Method of Contraception)

★★★★

20.2%

Contraceptive Care: All Women Ages 15 to 20 (Long Acting Reversible Method of Contraception)

★★★★

1.4%

Contraceptive Care: Postpartum Women Ages 15 to 20 (Most or Moderately Effective Method of Contraception within 3 Days of Delivery)

★★★★

1.8%

Contraceptive Care: Postpartum Women Ages 15 to 20 (Most or Moderately Effective Method of Contraception within 60 Days of Delivery)

★★★★

36.3%

Contraceptive Care: Postpartum Women Ages 15 to 20 (Long-Acting Reversible Method of Contraception within 3 Days of Delivery)

★★★★

0.5%

Contraceptive Care: Postpartum Women Ages 15 to 20 (Long-Acting Reversible Method of Contraception within 60 Days of Delivery)

★★★★

10.6%

Prenatal and Postpartum Care: Timeliness of Prenatal Care (Prenatal Care within the First Trimester or 42 Days of Medicaid/CHIP Enrollment)

★★★★

91.5%

Live Births Weighing Less Than 2,500 Grams

★★★★

9.7%

Prenatal and Postpartum Care: Postpartum Care (At Least One Visit on or Between 7 and 84 Days after Delivery)

★★★★

73.3%

Florida reporting on Primary Care Access and Preventive Care, 2020

Primary Care Access and Preventive Care

FL Rate	Worst	Median	Best

Adolescent Well-Care Visits: Ages 12 to 21

★★★★

62.8%

Childhood Immunization Status: Age 2 (Measles, Mumps, and Rubella (MMR) Vaccine)

★★★★

NR%

Childhood Immunization Status: Age 2 (Combination 3)

★★★★

74.4%

Chlamydia Screening in Women Ages 16 to 20

★★★★

61.7%

Developmental Screening in the First Three Years of Life: Ages 0 to 3

★★★★

15.3%

Immunizations for Adolescents: Age 13 (Human Papillomavirus (HPV) Series)

★★★★

40.9%

Immunizations for Adolescents: Age 13 (Combination 1: Meningococcal Conjugate and Tdap Vaccines)

★★★★

75.6%

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Ages 3 to 17 (Body Mass Index (BMI) Percentile Documentation)

★★★★

88.6%

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Ages 3 to 17 (Counseling for Nutrition)

★★★★

NR%

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Ages 3 to 17 (Counseling for Physical Activity)

★★★★

NR%

Well-Child Visits in the First 15 Months of Life (6 or More)

★★★★

72.5%

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

★★★★

79.2%

Source: Georgetown University Center for Children and Families analysis of the Centers for Medicaid and Medicare Services' (CMS) FFY 2020 Child Health Quality Measures Dataset. All figures reflect either Medicaid and CHIP beneficiaries combined or Medicaid alone. CHIP-only data was not used. Measures with fewer than 25 states reporting nationally are not reported by CMS and are not included in this analysis.

Maternal & Early Childhood

The health of children and pregnant women has been a long-standing national priority and Medicaid has been the primary means of backing up this commitment. A child's brain develops most rapidly in the earliest months and years of life, building the foundation for future lifelong success. Healthy child development begins with healthy parents who have access to health coverage before, during and after a pregnancy. The bonds and relationships formed in the earliest years of a child's life shape their early learning and development. Medicaid, along with CHIP, serves the vast majority of children in low-income families and covers about half of U.S. births each year. Scroll down to learn more about how this state is doing on child and maternal health care.

Quality Measures Florida

Florida reporting on Maternal and Perinatal Health, 2020

Maternal and Perinatal Health

FL Rate	Worst	Median	Best

Contraceptive Care: All Women Ages 15 to 20 (Most Effective or Moderately Effective Method of Contraception)

★★★★

20.2%

Contraceptive Care: All Women Ages 15 to 20 (Long Acting Reversible Method of Contraception)

★★★★

1.4%

Contraceptive Care: Postpartum Women Ages 15 to 20 (Most or Moderately Effective Method of Contraception within 3 Days of Delivery)

★★★★

1.8%

Contraceptive Care: Postpartum Women Ages 15 to 20 (Most or Moderately Effective Method of Contraception within 60 Days of Delivery)

★★★★

36.3%

Contraceptive Care: Postpartum Women Ages 15 to 20 (Long-Acting Reversible Method of Contraception within 3 Days of Delivery)

★★★★

0.5%

Contraceptive Care: Postpartum Women Ages 15 to 20 (Long-Acting Reversible Method of Contraception within 60 Days of Delivery)

★★★★

10.6%

Prenatal and Postpartum Care: Timeliness of Prenatal Care (Prenatal Care within the First Trimester or 42 Days of Medicaid/CHIP Enrollment)

★★★★

91.5%

Live Births Weighing Less Than 2,500 Grams

★★★★

9.7%

Prenatal and Postpartum Care: Postpartum Care (At Least One Visit on or Between 7 and 84 Days after Delivery)

★★★★

73.3%

Source: Georgetown University Center for Children and Families analysis of the Centers for Medicaid and Medicare Services' (CMS) FFY 2020 Child Health Quality Measures Dataset. All figures reflect either Medicaid and CHIP beneficiaries combined or Medicaid alone. CHIP-only data was not used. Measures with fewer than 25 states reporting nationally are not reported by CMS and are not included in this analysis.

This information was collected from the Georgetown University Center for Children and Families (CCF) Children's Health Care Report Card. CCF is a nonpartisan policy and research center, based at the McCourt School of Public Policy's Health Policy Institute, with a mission to expand and improve high-quality, affordable health coverage for America's children and families.

A	B	C	D	E	F	G
Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations						
	Previous Federal Fiscal Year	**Federal Fiscal Year #1**	**Federal Fiscal Year #2**	**Federal Fiscal Year #3**	**Federal Fiscal Year #4**	**Federal Fiscal Year #5**
State's Allotment	**$ 671,582,970**	**$ 671,582,970**	**$ 671,582,970**	**$ 671,582,970**	**$ 671,582,970**	**$ 671,582,970**
Funds Carried Over From Prior Year(s)	**$ 726,360,344**	**$ 795,423,959**	**$ 817,960,736**	**$ 685,901,504**	**$ 492,980,131**	**$ 252,945,150**
SUBTOTAL (Allotment + Funds Carried Over)	**$ 1,397,943,314**	**$ 1,467,006,929**	**$ 1,489,543,706**	**$ 1,357,484,474**	**$ 1,164,563,101**	**$ 924,528,120**
Reallocated Funds (Redistributed or Retained that are Currently Available)						
TOTAL (Subtotal + Reallocated funds)	**$ 1,397,943,314**	**$ 1,467,006,929**	**$ 1,489,543,706**	**$ 1,357,484,474**	**$ 1,164,563,101**	**$ 924,528,120**
State's Enhanced FMAP Rate	**72.04%**	**70.57%**	**70.02%**	**69.10%**	**68.59%**	**68.32%**
COST PROJECTIONS OF APPROVED SCHIP PLAN						
Benefit Costs						
Insurance payments						
Total Managed Care	$ 270,256,517	$ 520,296,387	$ 661,766,634	$ 716,483,935	$ 771,474,494	$ 828,810,713
per member/per month rate @ # of eligibles						
Total Fee for Service						
per member/per month rate @ # of eligibles						
Total Benefit Costs (Managed Care + Fee for Service)	$ 270,256,517	$ 520,296,387	$ 661,766,634	$ 716,483,935	$ 771,474,494	$ 828,810,713
(Offsetting beneficiary cost sharing payments) (negative number)						
Net Benefit Costs	$ 270,256,517	$ 520,296,387	$ 661,766,634	$ 716,483,935	$ 771,474,494	$ 828,810,713
Administration Costs						
Personnel	$ 2,074,489	$ 2,270,009	$ 2,270,009	$ 2,270,009	$ 2,270,009	$ 2,270,009
General administration	$ 156,800	$ 242,288	$ 242,288	$ 242,288	$ 242,288	$ 242,288
Contractors/Brokers	$ 15,849,491	$ 19,312,947	$ 20,544,171	$ 22,990,425	$ 23,507,600	$ 17,899,220
Claims Processing	$ -	$ -	$ -	$ -	$ -	$ -
Outreach/marketing costs	$ -	$ -	$ -	$ -	$ -	$ -
Other (specify) (Employee Expenses)	$ 87,479	$ 87,479	$ 87,479	$ 87,479	$ 87,479	$ 87,479
Total Administration Costs	$ 18,080,780	$ 21,825,244	$ 23,056,468	$ 25,502,722	$ 26,019,897	$ 20,411,517
10% Administrative Cap	$ 27,025,652	$ 52,029,639	$ 66,176,663	$ 71,648,393	$ 77,147,449	$ 82,881,071
Federal Title XXI Share	$ 207,703,772	$ 382,586,077	$ 479,506,288	$ 512,727,619	$ 547,009,377	$ 580,171,643
State Share	$ 80,633,525	$ 159,535,554	$ 205,316,814	$ 229,259,037	$ 250,485,013	$ 269,050,587
TOTAL COSTS OF APPROVED SCHIP PLAN	$ 288,337,297	$ 542,121,631	$ 684,823,102	$ 741,986,656	$ 797,494,391	$ 849,222,230
COST PROJECTIONS FOR DEMONSTRATION PROPOSAL						
Benefit Costs for Demonstration Population #1 (specify)						
Insurance payments						
Total Managed Care		$16,999,053	$69,794,099	$106,984,015	$125,152,604	$135,457,940
per member/per month rate @ # of eligibles						
Total Fee for Service						
per member/per month rate @ # of eligibles						
Total Benefit Costs (Managed Care + Fee for Service)	$ -	$ 16,999,053	$ 69,794,099	$ 106,984,015	$ 125,152,604	$ 135,457,940
Benefit Costs for Demonstration Population #2 (specify)						
Insurance payments						
Total Managed Care						
per member/per month rate @ # of eligibles						
Total Fee for Service						
per member/per month rate @ # of eligibles						
Total Benefit Costs (Managed Care + Fee for Service)	$ -	$ -	$ -	$ -	$ -	$ -
Benefit Costs for Demonstration Population #3 (specify)						
Insurance payments						
Total Managed Care						
per member/per month rate @ # of eligibles						
Total Fee for Service						
per member/per month rate @ # of eligibles						
Total Benefit Costs (Managed Care + Fee for Service)	$ -	$ -	$ -	$ -	$ -	$ -
Benefit Costs for Demonstration Population #4 (specify)						
Insurance payments						
Total Managed Care						
per member/per month rate @ # of eligibles						
Total Fee for Service						
per member/per month rate @ # of eligibles						
Total Benefit Costs (Managed Care + Fee for Service)	$ -	$ -	$ -	$ -	$ -	$ -
Total Benefit Costs (For All Demonstration Populations)	$ -	$ 16,999,053	$ 69,794,099	$ 106,984,015	$ 125,152,604	$ 135,457,940
(Offsetting beneficiary cost sharing payments - if applicable)						
Net Benefit Costs	$ -	$ 16,999,053	$ 69,794,099	$ 106,984,015	$ 125,152,604	$ 135,457,940

Administration Costs							
Personnel		$ 456,942	$ 456,942	$ 456,942	$ 456,942	$ 456,942	
General administration		$ 14,000	$ 14,000	$ 14,000	$ 14,000	$ 14,000	
Contractors/Brokers		$ 1,686,303	$ 1,634,728	$ 1,558,344	$ 1,720,124	$ 1,720,079	
Claims Processing							
Outreach/marketing costs							
Other (specify)							
Total Administration Costs	$ -	$ 2,157,245	$ 2,105,670	$ 2,029,286	$ 2,191,066	$ 2,191,021	
10% Administrative Cap	$ -	$ 1,699,905	$ 6,979,410	$ 10,698,402	$ 12,515,260	$ 13,545,794	
Federal Title XXI Share	$ -	$ 13,518,983	$ 50,343,499	$ 75,330,372	$ 87,346,296	$ 94,039,017	
State Title XXI Share	$ -	$ 5,637,315	$ 21,556,270	$ 33,682,930	$ 39,997,373	$ 43,609,944	
TOTAL COSTS FOR DEMONSTRATION	$ -	$ 19,156,298	$ 71,899,769	$ 109,013,301	$ 127,343,670	$ 137,648,961	
TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)	$ 288,337,297	$ 561,277,929	$ 756,722,871	$ 850,999,958	$ 924,838,060	$ 986,871,191	
Federal Title XXI Share	$ 207,703,772	$ 396,105,060	$ 529,849,787	$ 588,057,991	$ 634,355,674	$ 674,210,660	
State Title XXI Share	$ 80,633,525	$ 165,172,869	$ 226,873,084	$ 262,941,967	$ 290,482,386	$ 312,660,531	
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	$ 1,397,943,314	$ 1,467,006,929	$ 1,489,543,706	$ 1,357,484,474	$ 1,164,563,101	$ 924,528,120	
Total Federal Title XXI Program Costs (State Plan + Demonstration)	$ 207,703,772	$ 396,105,060	$ 529,849,787	$ 588,057,991	$ 634,355,674	$ 674,210,660	
Unused Title XXI Funds Expiring (Allotment or Reallocated)							
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	$ 1,190,239,542	$ 1,070,901,869	$ 959,693,919	$ 769,426,484	$ 530,207,428	$ 250,317,460	

Note: A Federal Fiscal Year (FFY) is October 1 through September 30.

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 3

"Implementation Update to the House Select Committee on Health Innovation"

Select Committee on Health Innovation

Monday, October 16, 2023
3:30 PM – 5:30 PM
Morris Hall (17 HOB)

Meeting Packet

Paul Renner
Speaker

Kaylee Tuck
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Select Committee on Health Innovation

Start Date and Time:	Monday, October 16, 2023 03:30 pm
End Date and Time:	Monday, October 16, 2023 05:30 pm
Location:	Morris Hall (17 HOB)
Duration:	2.00 hrs

Legislation implementation briefing by the Agency for Health Care Administration:
-HB 967 (2023) Medicaid Coverage of Continuous Glucose Monitors
-HB 121 (2023) Florida Kidcare Program Eligibility
-SB 2510 (2023) Health/Pilot Program for Individuals with Developmental Disabilities
-HB 763 (2020) Patient Safety Culture Surveys
-Statewide Medicaid Managed Care procurement process update

To submit an electronic appearance form, and for information about attending or testifying at a committee meeting, please see the "Visiting the House" tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 10/09/2023 3:05PM by Arnold.Sabrina

Implementation Update

House Select Committee on Health Innovation

October 16, 2023

Agency Overview

MISSION

Better Health Care for all Floridians

CORE FUNCTIONS

- State's Chief Health Policy and Planning Entity
- Administering the Florida Medicaid Program
- Licensure and Regulation of nearly 50,000 health care facilities

We leverage technology to support these core functions and all agency operations.

Agency Objectives

ONE AHCA

We are one agency, one team.

COST EFFECTIVE

We leverage Florida's buying power to deliver high quality care at the lowest cost to taxpayers.

TRANSPARENT

We support initiatives that promote transparency and empower consumers to make well informed healthcare decisions.

HIGH QUALITY

We emphasize quality in all that we do to improve health outcomes, always putting the individual first.

Implementation Updates

- HB 121 - Florida KidCare Program Eligibility (2023)
- HB 967 - Medicaid Coverage of Continuous Glucose Monitors (2023)
- SB 2510 - Pilot Program for Individuals with Developmental Disabilities (2023)
- Statewide Medicaid Managed Care Procurement Process Update
- HB 763 - Patient Safety Culture Surveys (2020)

HB 121 – Florida KidCare Program Eligibility
What is CHIP?

- The Children's Health Insurance Program (CHIP) provides coverage to uninsured children in families with income that is too high to qualify for Medicaid.
- CHIP is funded jointly by the federal government and states.
- In Florida, the program is operated through a partnership.
  - Three state agencies:
    - Agency for Health Care Administration (AHCA)
    - Department of Children and Families (DCF)
    - Department of Health (DOH)
  - Florida Healthy Kids Corporation (FHKC): a non-profit organization

HB 121 – Florida KidCare Program Eligibility
What is CHIP?

- The Agency for Health Care Administration (AHCA) is the lead agency for the Children's Health Insurance Programs (Title XXI–CHIP). AHCA works with the federal government to make sure the Florida KidCare program follows all federal laws and rules.
- Florida Healthy Kids Corporation determines eligibility for CHIP and administers the Healthy Kids program component.

HB 121 - Florida KidCare Program Eligibility - What is CHIP?

Children's Health Insurance Program (CHIP)

Parents pay a small monthly premium that covers all eligible children in the household.

CHIP Buy-In Program

- Provides CHIP benefits to families earning more than CHIP income limits allow.
- Parents pay a per-child monthly premium, on average $250 per child per month.
- Florida is one of few states providing this option as a bridge between subsidized and other coverage.

HB 121 – Florida KidCare Program Eligibility

HB 121 made the following changes:

1. Increased the income eligibility for children in the Children's Health Insurance Program (CHIP) from 200% to 300% of the FPL
2. Increased the number of premium tiers that increase with each level as a percentage of the FPL
3. Effective January 1, 2024

HB 121 - Florida KidCare Program Eligibility

Approximately 68,000 Florida children are uninsured whose household incomes fall between 200% and 300% of the FPL

- New premium tiers create a sliding scale, softening the "fiscal cliff"
- The more a family earns, the more the family contributes

CHIP Income Limits - Before & After HB 121

Family of 2 - 200%
$39,440

Family of 2 - 300%
$59,160

Family of 4 - 200%
$60,000

Family of 4 - 300%
$90,000

Family of 6 - 200%
$80,560

Family of 6 - 300%
$120,840

HB 121 - New Monthly Premium Tiers

One 'family' premium covers all eligible children in the household

Tier 1 - 133.01% - 175% FPL
$17

Tier 2 - 175.01% - 200% FPL
$38

Tier 3 - 200.01% - 225% FPL
$64

Tier 4 - 225.01% - 250% FPL
$94

Tier 5 - 250.01% - 275% FPL
$130

Tier 6 - 275.01% - 300% FPL
$170

Income Limits and Premium Tiers

	Medicaid for Children	MediKids + Florida Healthy Kids + CMS Plan					
Family Size	**$0 Premium** Up to 133% FPL	**$17 Premium** 133.01 – 175% FPL	**$38 Premium** 175.01 – 200% FPL	**$64 Premium** 200.01 – 225% FPL	**$94 Premium** 225.01 – 250% FPL	**$130 Premium** 250.01 – 275% FPL	**$170 Premium** 275.01 – 300% FPL
1	Up to $19,392	$25,515	$29,160	$32,805	$36,450	$40,095	$43,740
2	Up to $26,232	$34,510	$39,440	$44,370	$49,300	$54,230	$59,160
3	Up to $33,072	$43,505	$49,720	$55,935	$62,150	$68,365	$74,580
4	Up to $39,900	$52,500	$60,000	$67,500	$75,000	$82,500	$90,000
5	Up to $46,740	$61,495	$70,280	$79,065	$87,850	$96,635	$105,420
6	Up to $53,580	$70,490	$80,560	$90,630	$100,700	$110,770	$120,840
7	Up to $60,420	$79,485	$90,840	$102,195	$113,550	$124,905	$136,260
8	Up to $67,248	$88,480	$101,120	$113,760	$126,400	$139,905	$151,680

These annual income guidelines are for informational purposes only.
Florida KidCare eligibility depends on other factors beyond a family's annual income.

HB 121 – Florida KidCare Program Implementation

Steps	Status	Partner
Establish new tiers and premiums	Completed	Florida Healthy Kids Corporation
Federal approval	Pending	AHCA
System changes	Pending	Florida Healthy Kids Corporation and DCF
System testing	Pending	Florida Healthy Kids and AHCA

Steps Toward Implementation

Requirements Gathering

May - August

- Document necessary system changes
- Develop system testing plan
- Engage with partner state agencies

Message Testing & Development

August - October

- Stakeholder collaboration
- Market research and polling
- Campaign development

Testing & Deployment

October - November

- Internal testing in progress
- Testing with DCF in progress
- Current customer notifications mailed

HB 121 Implementation

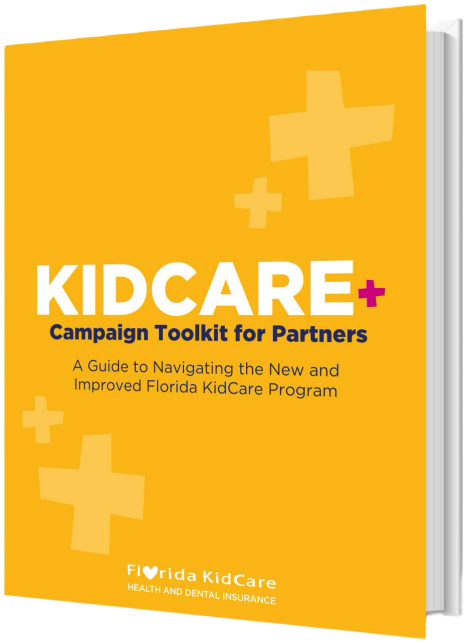
Communications and Outreach

A multi-pronged approach with two main audiences:

Current Enrollees

Potential Enrollees

HB 121 - Community Outreach



Local Partners

Statewide network of partners including children's hospitals, health clinics, food banks, etc.

Health Plans

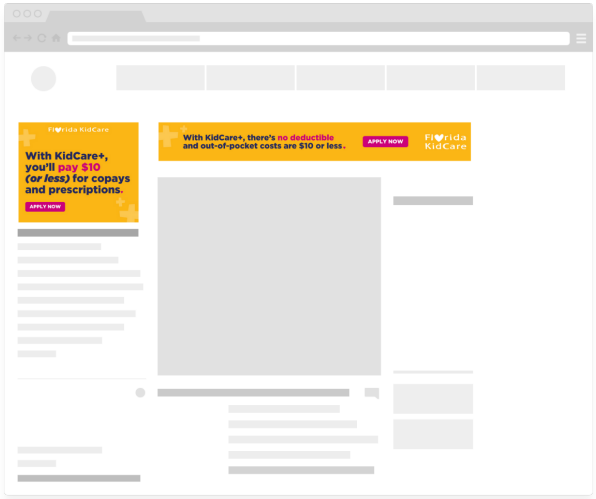
Leveraging outreach teams of contracted health plans to connect in local communities of high need

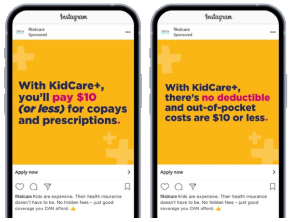
CVS Pharmacy

- In-store radio PSAs
- Events in select locations
- Print ad on prescription bags

Sample Advertisements

Targeted advertisements with messaging tailored to each target audience (based on location, language, etc.) and available in English, Spanish and Creole.





HB 967 - Medicaid Coverage of Continuous Glucose Monitors

- During Florida's 2023 Legislative Session, HB 967 passed, and the Governor approved, which made changes to Florida Medicaid Coverage of Continuous Glucose Monitors (CGM).
- Currently, Florida Medicaid Fee For Services (FFS) recipients receive their diabetic supplies through a durable medical equipment (DME) provider.
  - Currently, CGM products, limited to those listed specifically on the DME fee schedule, are available to children only.
- For drugs and products covered under the Medicaid Pharmacy benefit, multiple products are available, with certain products for which AHCA is able to negotiate a manufacturer rebate being **preferred**.

HB 967 - Medicaid Coverage of Continuous Glucose Monitors

HB 967 made the following changes:

- Required AHCA to provide coverage for CGMs for children and adults under the Medicaid pharmacy benefit if:
  - Recipient has a diagnosis of Type 1 or 2 diabetes, gestational diabetes, or any other type of diabetes treated with insulin; and
  - A physician has prescribed insulin to treat the recipient's diabetes and a CGM to assist the recipient and practitioner in managing the recipient's diabetes.
- Defines Continuous Glucose Monitors (CGM) for the purpose of Medicaid coverage.

HB 967 - Medicaid Coverage of Continuous Glucose Monitors - Implementation

DME and Pharmacy Rules Updates:
Notice of Rule Development Workshop held in September 2023 and anticipate final rule by January

Contract for negotiation of rebates for diabetic supplies at the best price

Create a Preferred Product List (PPL)

SB 2510- Pilot Program for Individuals with Developmental Disabilities

- During Florida's 2023 Legislative Session, language passed which made changes to the services available to those in Pre-Enrollment for Florida's iBudget Medicaid waiver.
- The iBudget Waiver is designed to promote and maintain the health of eligible individuals with developmental disabilities, to provide medically necessary supports and services to delay or prevent institutionalization, and to foster the principles and appreciation of self-determination.

SB 2510- Pilot Program for Individuals with Developmental Disabilities

- The Agency for Persons with Disabilities (APD) operates the iBudget waiver and maintains Pre-Enrollment categories.

iBudget	Pre-Enrollment
Receive HCBS services through APD	Not eligible to receive HCBS services
Receive medical services through Medicaid FFS or Managed Care • Enrollees can voluntarily choose to enroll in managed care for their Medicaid services, but are not required.	Receive medical services (if Medicaid eligible) through Medicaid FFS or Managed Care • Enrollees can voluntarily choose to enroll in managed care for their Medicaid services, but are not required.

SB 2510- Pilot Program for Individuals with Developmental Disabilities

- During Florida's 2023 Legislative Session, SB 2510 was passed which included language directing the Agency for Health Care Administration, in collaboration and consultation with the Agency for Persons with Disabilities, to implement a managed care pilot program for individuals with intellectual and developmental disabilities.

SB 2510- Pilot Program for Individuals with Developmental Disabilities

- FY 2023-24 budget provides coverage for up to 600 Medicaid recipients in the iBudget Pre-Enrollment group.
- Enrollment in the Pilot is voluntary.

- Operate in two Statewide Medicaid Managed Care Regions.
  - Regions D and I
  - D: Hillsborough, Polk, Manatee, Hardee, Highlands
  - I: Miami-Dade, Monroe

- Provide a comprehensive service package of all services under the Long Term Care (LTC) program, Managed Medical Assistance (MMA) program, and iBudget waiver.

- One plan per region chosen by invitation to negotiate (ITN).
- To qualify, a plan must have a contract to provide Medicaid LTC services under s. 409.981 as a result of an ITN.

SB 2510 - Pilot Program for Individuals with Developmental Disabilities

Steps	Status	Notes
Submit Request for Federal Authority by September 1, 2023	✓	AHCA held the required public comment period from 7/28-8/27/23 and submitted the request for a new 1915c waiver on September 1.
Receive approval from Federal CMS	In Progress	No initial concerns received from CMS
Conduct Invitation to Negotiate to select one plan to participate in the Pilot in each region	In Progress	Anticipate posting early Fall 2023.
Submit initial status report to Florida Legislature by December 31, 2023	In Progress	
Award contracts pursuant to the ITN and begin enrollment by January 31, 2024	In Progress	

Statewide Medicaid Managed Care (SMMC) Re-Procurement

The estimated value of all managed care contracts combined that may result from the ITN is between $120-150 billion over the anticipated six (6) year term.

SMMC ACTIVITY	DATE/TIME
Solicitation Issued by AHCA	April 11, 2023
Deadline for Receipt of Responses	October 25, 2023 12:00 p.m.
Public Opening of Responses	October 25, 2023 3:00 p.m.
Anticipated Posting of Respondent Names for Provider Comment	October 27, 2023
Deadline for Receipt of Provider Comments	November 9, 2023 5:00 p.m.
Anticipated Dates for Negotiations	December 4, 2023 through January 26, 2024
Anticipated Posting of Notice of Intent to Award	February 23, 2024

Statewide Prepaid Dental Program Re-Procurement

The estimated value of all dental contracts combined that may result from the ITN is between $2 - $3 billion over the anticipated six (6) year term.

DENTAL ACTIVITY	DATE/TIME
Solicitation Issued by AHCA	October 6, 2023
Deadline for Receipt of Written Questions	October 27, 2023 2:00 p.m.
Date for Agency Responses to Written Questions	November 17, 2023
Deadline for Receipt of Responses	January 5, 2024 12:00 p.m.
Public Opening of Responses	January 5, 2024 2:00 p.m.
Anticipated Posting of Respondent Names for Provider Comment	January 8, 2024
Deadline for Receipt of Provider Comments	January 22, 2024 5:00 p.m. (or 10 business days after Respondent Names are Posted)
Anticipated Dates for Negotiations	February 5, 2024 through March 1, 2024
Anticipated Posting of Notice of Intent to Award	March 29, 2024

Patient Safety Culture Surveys

- Patient safety culture is the extent to which the beliefs, values, and norms shared by the staff of a health care organization support and promote patient safety.
- Patient safety culture surveys are used to measure patient safety culture by determining what is rewarded, supported, expected and accepted in health care organizations as it relates to patient safety.
  - The intent is to give health care organizations an understanding of the safety-related perceptions and attitudes of its managers and staff and are used as diagnostic tools to identify areas for improvement.
  - These surveys can also be used to measure organizational conditions that can lead to adverse incidents and patient harm.

HB 763 (2020) - Patient Safety Culture Surveys

HB 763 required hospitals and Ambulatory Surgery Centers (ASCs) to conduct patient safety culture surveys on facility staff.

- Required the facilities to conduct the surveys anonymously to encourage staff employed by or working in the facility to complete the survey.
- Authorized the facilities to contract to administer the survey and to develop an internal action plan to identify survey measures to improve on between surveys.
- Required AHCA to collect, compile, and publish patient safety culture survey data submitted by the facilities.

HB 763 - Patient Safety Culture Surveys - Requirements

- Facilities must use surveys from the federal Agency for Healthcare Research and Quality (ARQH).
  - AHRQ is the lead federal agency charged with supporting research designed to improve the quality of health care, reduce costs, address patient safety and medical errors, and broaden access to essential services.
  - Although the AHRQ survey is voluntary, they offer the survey for free and allow facilities to submit their results to a repository to help them determine their progress.

- AHCA was tasked modifying the ARQH surveys to include Florida-specific questions.
  - The two additional questions gauge the likelihood of staff to seek care for themselves or their family within the facility.

HB 763 - Patient Safety Culture Surveys - Topics

This survey requirement is for 306 licensed hospitals and 479 licensed ASCs in the state of Florida and covers these topics:

Communication Openness	Hospital Management Support for Patient Safety
Feedback & Communication About Errors	Overall Perception of Safety
Frequency of Events Reported	Staffing
Organizational Learning-Continuous Improvement	Supervisor/Manager Expectations & Actions Promoting Patient Safety
Hospital Handoffs & Transitions	Teamwork Across Hospital Units
Non-punitive Response to Errors	Teamwork within Units
*Likelihood of Seeking Care at Surveying Facility	*Likelihood of Seeking Care at Respondent's Unit or Work Area
***Represents Florida-specific questions.**	

HB 763 - Patient Safety Culture Surveys - Additional Agency Requirements

- AHCA's responsibilities are to define the survey format, create a reporting intake method, define the data submission specifications in rule, compile survey data, and publish a report. The agency:
  - Developed a Patient Safety Culture Survey (PSCS) process to assess the status of patient safety culture in hospitals and ASCs;
  - Designed an informational webpage with general information, a system guide, FAQs, forms, and data entry tools to assist with survey data submission;
  - Developed a system application; and
  - Promulgated rule 59A-35.115, Patient Safety Surveys, January 2023.

HB 763 - Patient Safety Culture Surveys - Reporting Details

- Facility registration begins **January 2025.**
- Initial reporting period will be **June 1, 2025 – August 31, 2025.**
- During rulemaking, hospitals requested to report at the same time as ASCs. This aligns with their federal patient safety reporting timelines for hospitals and ASCs.
- The survey tool is available on-line and can be administered any time before the required reporting periods.

QUESTIONS?

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 4

"2026 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)"

2026 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)

Dollars Per Year

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	7,980.00	11,970.00	15,960.00	19,950.00	20,748.00	21,226.80	21,546.00	22,024.80	23,940.00	27,930.00	28,728.00	29,526.00
2	10,820.00	16,230.00	21,640.00	27,050.00	28,132.00	28,781.20	29,214.00	29,863.20	32,460.00	37,870.00	38,952.00	40,034.00
3	13,660.00	20,490.00	27,320.00	34,150.00	35,516.00	36,335.60	36,882.00	37,701.60	40,980.00	47,810.00	49,176.00	50,542.00
4	16,500.00	24,750.00	33,000.00	41,250.00	42,900.00	43,890.00	44,550.00	45,540.00	49,500.00	57,750.00	59,400.00	61,050.00
5	19,340.00	29,010.00	38,680.00	48,350.00	50,284.00	51,444.40	52,218.00	53,378.40	58,020.00	67,690.00	69,624.00	71,558.00
6	22,180.00	33,270.00	44,360.00	55,450.00	57,668.00	58,998.80	59,886.00	61,216.80	66,540.00	77,630.00	79,848.00	82,066.00
7	25,020.00	37,530.00	50,040.00	62,550.00	65,052.00	66,553.20	67,554.00	69,055.20	75,060.00	87,570.00	90,072.00	92,574.00
8	27,860.00	41,790.00	55,720.00	69,650.00	72,436.00	74,107.60	75,222.00	76,893.60	83,580.00	97,510.00	100,296.00	103,082.00
9	30,700.00	46,050.00	61,400.00	76,750.00	79,820.00	81,662.00	82,890.00	84,732.00	92,100.00	107,450.00	110,520.00	113,590.00
10	33,540.00	50,310.00	67,080.00	83,850.00	87,204.00	89,216.40	90,558.00	92,570.40	100,620.00	117,390.00	120,744.00	124,098.00
11	36,380.00	54,570.00	72,760.00	90,950.00	94,588.00	96,770.80	98,226.00	100,408.80	109,140.00	127,330.00	130,968.00	134,606.00
12	39,220.00	58,830.00	78,440.00	98,050.00	101,972.00	104,325.20	105,894.00	108,247.20	117,660.00	137,270.00	141,192.00	145,114.00
13	42,060.00	63,090.00	84,120.00	105,150.00	109,356.00	111,879.60	113,562.00	116,085.60	126,180.00	147,210.00	151,416.00	155,622.00
14	44,900.00	67,350.00	89,800.00	112,250.00	116,740.00	119,434.00	121,230.00	123,924.00	134,700.00	157,150.00	161,640.00	166,130.00

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	31,920.00	35,910.00	39,900.00	43,890.00	47,880.00	51,870.00	55,860.00	59,850.00	63,840.00	79,800.00	95,760.00	111,720.00
2	43,280.00	48,690.00	54,100.00	59,510.00	64,920.00	70,330.00	75,740.00	81,150.00	86,560.00	108,200.00	129,840.00	151,480.00
3	54,640.00	61,470.00	68,300.00	75,130.00	81,960.00	88,790.00	95,620.00	102,450.00	109,280.00	136,600.00	163,920.00	191,240.00
4	66,000.00	74,250.00	82,500.00	90,750.00	99,000.00	107,250.00	115,500.00	123,750.00	132,000.00	165,000.00	198,000.00	231,000.00
5	77,360.00	87,030.00	96,700.00	106,370.00	116,040.00	125,710.00	135,380.00	145,050.00	154,720.00	193,400.00	232,080.00	270,760.00
6	88,720.00	99,810.00	110,900.00	121,990.00	133,080.00	144,170.00	155,260.00	166,350.00	177,440.00	221,800.00	266,160.00	310,520.00
7	100,080.00	112,590.00	125,100.00	137,610.00	150,120.00	162,630.00	175,140.00	187,650.00	200,160.00	250,200.00	300,240.00	350,280.00
8	111,440.00	125,370.00	139,300.00	153,230.00	167,160.00	181,090.00	195,020.00	208,950.00	222,880.00	278,600.00	334,320.00	390,040.00
9	122,800.00	138,150.00	153,500.00	168,850.00	184,200.00	199,550.00	214,900.00	230,250.00	245,600.00	307,000.00	368,400.00	429,800.00
10	134,160.00	150,930.00	167,700.00	184,470.00	201,240.00	218,010.00	234,780.00	251,550.00	268,320.00	335,400.00	402,480.00	469,560.00
11	145,520.00	163,710.00	181,900.00	200,090.00	218,280.00	236,470.00	254,660.00	272,850.00	291,040.00	363,800.00	436,560.00	509,320.00
12	156,880.00	176,490.00	196,100.00	215,710.00	235,320.00	254,930.00	274,540.00	294,150.00	313,760.00	392,200.00	470,640.00	549,080.00
13	168,240.00	189,270.00	210,300.00	231,330.00	252,360.00	273,390.00	294,420.00	315,450.00	336,480.00	420,600.00	504,720.00	588,840.00
14	179,600.00	202,050.00	224,500.00	246,950.00	269,400.00	291,850.00	314,300.00	336,750.00	359,200.00	449,000.00	538,800.00	628,600.00

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2026 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)

Dollars Per Month

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	665.00	997.50	1,330.00	1,662.50	1,729.00	1,768.90	1,795.50	1,835.40	1,995.00	2,327.50	2,394.00	2,460.50
2	901.67	1,352.50	1,803.33	2,254.17	2,344.33	2,398.43	2,434.50	2,488.60	2,705.00	3,155.83	3,246.00	3,336.17
3	1,138.33	1,707.50	2,276.67	2,845.83	2,959.67	3,027.97	3,073.50	3,141.80	3,415.00	3,984.17	4,098.00	4,211.83
4	1,375.00	2,062.50	2,750.00	3,437.50	3,575.00	3,657.50	3,712.50	3,795.00	4,125.00	4,812.50	4,950.00	5,087.50
5	1,611.67	2,417.50	3,223.33	4,029.17	4,190.33	4,287.03	4,351.50	4,448.20	4,835.00	5,640.83	5,802.00	5,963.17
6	1,848.33	2,772.50	3,696.67	4,620.83	4,805.67	4,916.57	4,990.50	5,101.40	5,545.00	6,469.17	6,654.00	6,838.83
7	2,085.00	3,127.50	4,170.00	5,212.50	5,421.00	5,546.10	5,629.50	5,754.60	6,255.00	7,297.50	7,506.00	7,714.50
8	2,321.67	3,482.50	4,643.33	5,804.17	6,036.33	6,175.63	6,268.50	6,407.80	6,965.00	8,125.83	8,358.00	8,590.17
9	2,558.33	3,837.50	5,116.67	6,395.83	6,651.67	6,805.17	6,907.50	7,061.00	7,675.00	8,954.17	9,210.00	9,465.83
10	2,795.00	4,192.50	5,590.00	6,987.50	7,267.00	7,434.70	7,546.50	7,714.20	8,385.00	9,782.50	10,062.00	10,341.50
11	3,031.67	4,547.50	6,063.33	7,579.17	7,882.33	8,064.23	8,185.50	8,367.40	9,095.00	10,610.83	10,914.00	11,217.17
12	3,268.33	4,902.50	6,536.67	8,170.83	8,497.67	8,693.77	8,824.50	9,020.60	9,805.00	11,439.17	11,766.00	12,092.83
13	3,505.00	5,257.50	7,010.00	8,762.50	9,113.00	9,323.30	9,463.50	9,673.80	10,515.00	12,267.50	12,618.00	12,968.50
14	3,741.67	5,612.50	7,483.33	9,354.17	9,728.33	9,952.83	10,102.50	10,327.00	11,225.00	13,095.83	13,470.00	13,844.17

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	2,660.00	2,992.50	3,325.00	3,657.50	3,990.00	4,322.50	4,655.00	4,987.50	5,320.00	6,650.00	7,980.00	9,310.00
2	3,606.67	4,057.50	4,508.33	4,959.17	5,410.00	5,860.83	6,311.67	6,762.50	7,213.33	9,016.67	10,820.00	12,623.33
3	4,553.33	5,122.50	5,691.67	6,260.83	6,830.00	7,399.17	7,968.33	8,537.50	9,106.67	11,383.33	13,660.00	15,936.67
4	5,500.00	6,187.50	6,875.00	7,562.50	8,250.00	8,937.50	9,625.00	10,312.50	11,000.00	13,750.00	16,500.00	19,250.00
5	6,446.67	7,252.50	8,058.33	8,864.17	9,670.00	10,475.83	11,281.67	12,087.50	12,893.33	16,116.67	19,340.00	22,563.33
6	7,393.33	8,317.50	9,241.67	10,165.83	11,090.00	12,014.17	12,938.33	13,862.50	14,786.67	18,483.33	22,180.00	25,876.67
7	8,340.00	9,382.50	10,425.00	11,467.50	12,510.00	13,552.50	14,595.00	15,637.50	16,680.00	20,850.00	25,020.00	29,190.00
8	9,286.67	10,447.50	11,608.33	12,769.17	13,930.00	15,090.83	16,251.67	17,412.50	18,573.33	23,216.67	27,860.00	32,503.33
9	10,233.33	11,512.50	12,791.67	14,070.83	15,350.00	16,629.17	17,908.33	19,187.50	20,466.67	25,583.33	30,700.00	35,816.67
10	11,180.00	12,577.50	13,975.00	15,372.50	16,770.00	18,167.50	19,565.00	20,962.50	22,360.00	27,950.00	33,540.00	39,130.00
11	12,126.67	13,642.50	15,158.33	16,674.17	18,190.00	19,705.83	21,221.67	22,737.50	24,253.33	30,316.67	36,380.00	42,443.33
12	13,073.33	14,707.50	16,341.67	17,975.83	19,610.00	21,244.17	22,878.33	24,512.50	26,146.67	32,683.33	39,220.00	45,756.67
13	14,020.00	15,772.50	17,525.00	19,277.50	21,030.00	22,782.50	24,535.00	26,287.50	28,040.00	35,050.00	42,060.00	49,070.00
14	14,966.67	16,837.50	18,708.33	20,579.17	22,450.00	24,320.83	26,191.67	28,062.50	29,933.33	37,416.67	44,900.00	52,383.33

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2026 Poverty Guidelines: Alaska

Dollars Per Year

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	9,975.00	14,962.50	19,950.00	24,937.50	25,935.00	26,533.50	26,932.50	27,531.00	29,925.00	34,912.50	35,910.00	36,907.50
2	13,525.00	20,287.50	27,050.00	33,812.50	35,165.00	35,976.50	36,517.50	37,329.00	40,575.00	47,337.50	48,690.00	50,042.50
3	17,075.00	25,612.50	34,150.00	42,687.50	44,395.00	45,419.50	46,102.50	47,127.00	51,225.00	59,762.50	61,470.00	63,177.50
4	20,625.00	30,937.50	41,250.00	51,562.50	53,625.00	54,862.50	55,687.50	56,925.00	61,875.00	72,187.50	74,250.00	76,312.50
5	24,175.00	36,262.50	48,350.00	60,437.50	62,855.00	64,305.50	65,272.50	66,723.00	72,525.00	84,612.50	87,030.00	89,447.50
6	27,725.00	41,587.50	55,450.00	69,312.50	72,085.00	73,748.50	74,857.50	76,521.00	83,175.00	97,037.50	99,810.00	102,582.50
7	31,275.00	46,912.50	62,550.00	78,187.50	81,315.00	83,191.50	84,442.50	86,319.00	93,825.00	109,462.50	112,590.00	115,717.50
8	34,825.00	52,237.50	69,650.00	87,062.50	90,545.00	92,634.50	94,027.50	96,117.00	104,475.00	121,887.50	125,370.00	128,852.50
9	38,375.00	57,562.50	76,750.00	95,937.50	99,775.00	102,077.50	103,612.50	105,915.00	115,125.00	134,312.50	138,150.00	141,987.50
10	41,925.00	62,887.50	83,850.00	104,812.50	109,005.00	111,520.50	113,197.50	115,713.00	125,775.00	146,737.50	150,930.00	155,122.50
11	45,475.00	68,212.50	90,950.00	113,687.50	118,235.00	120,963.50	122,782.50	125,511.00	136,425.00	159,162.50	163,710.00	168,257.50
12	49,025.00	73,537.50	98,050.00	122,562.50	127,465.00	130,406.50	132,367.50	135,309.00	147,075.00	171,587.50	176,490.00	181,392.50
13	52,575.00	78,862.50	105,150.00	131,437.50	136,695.00	139,849.50	141,952.50	145,107.00	157,725.00	184,012.50	189,270.00	194,527.50
14	56,125.00	84,187.50	112,250.00	140,312.50	145,925.00	149,292.50	151,537.50	154,905.00	168,375.00	196,437.50	202,050.00	207,662.50

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	39,900.00	44,887.50	49,875.00	54,862.50	59,850.00	64,837.50	69,825.00	74,812.50	79,800.00	99,750.00	119,700.00	139,650.00
2	54,100.00	60,862.50	67,625.00	74,387.50	81,150.00	87,912.50	94,675.00	101,437.50	108,200.00	135,250.00	162,300.00	189,350.00
3	68,300.00	76,837.50	85,375.00	93,912.50	102,450.00	110,987.50	119,525.00	128,062.50	136,600.00	170,750.00	204,900.00	239,050.00
4	82,500.00	92,812.50	103,125.00	113,437.50	123,750.00	134,062.50	144,375.00	154,687.50	165,000.00	206,250.00	247,500.00	288,750.00
5	96,700.00	108,787.50	120,875.00	132,962.50	145,050.00	157,137.50	169,225.00	181,312.50	193,400.00	241,750.00	290,100.00	338,450.00
6	110,900.00	124,762.50	138,625.00	152,487.50	166,350.00	180,212.50	194,075.00	207,937.50	221,800.00	277,250.00	332,700.00	388,150.00
7	125,100.00	140,737.50	156,375.00	172,012.50	187,650.00	203,287.50	218,925.00	234,562.50	250,200.00	312,750.00	375,300.00	437,850.00
8	139,300.00	156,712.50	174,125.00	191,537.50	208,950.00	226,362.50	243,775.00	261,187.50	278,600.00	348,250.00	417,900.00	487,550.00
9	153,500.00	172,687.50	191,875.00	211,062.50	230,250.00	249,437.50	268,625.00	287,812.50	307,000.00	383,750.00	460,500.00	537,250.00
10	167,700.00	188,662.50	209,625.00	230,587.50	251,550.00	272,512.50	293,475.00	314,437.50	335,400.00	419,250.00	503,100.00	586,950.00
11	181,900.00	204,637.50	227,375.00	250,112.50	272,850.00	295,587.50	318,325.00	341,062.50	363,800.00	454,750.00	545,700.00	636,650.00
12	196,100.00	220,612.50	245,125.00	269,637.50	294,150.00	318,662.50	343,175.00	367,687.50	392,200.00	490,250.00	588,300.00	686,350.00
13	210,300.00	236,587.50	262,875.00	289,162.50	315,450.00	341,737.50	368,025.00	394,312.50	420,600.00	525,750.00	630,900.00	736,050.00
14	224,500.00	252,562.50	280,625.00	308,687.50	336,750.00	364,812.50	392,875.00	420,937.50	449,000.00	561,250.00	673,500.00	785,750.00

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2026 Poverty Guidelines: Alaska

Dollars Per Month

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	831.25	1,246.88	1,662.50	2,078.13	2,161.25	2,211.13	2,244.38	2,294.25	2,493.75	2,909.38	2,992.50	3,075.63
2	1,127.08	1,690.63	2,254.17	2,817.71	2,930.42	2,998.04	3,043.13	3,110.75	3,381.25	3,944.79	4,057.50	4,170.21
3	1,422.92	2,134.38	2,845.83	3,557.29	3,699.58	3,784.96	3,841.88	3,927.25	4,268.75	4,980.21	5,122.50	5,264.79
4	1,718.75	2,578.13	3,437.50	4,296.88	4,468.75	4,571.88	4,640.63	4,743.75	5,156.25	6,015.63	6,187.50	6,359.38
5	2,014.58	3,021.88	4,029.17	5,036.46	5,237.92	5,358.79	5,439.38	5,560.25	6,043.75	7,051.04	7,252.50	7,453.96
6	2,310.42	3,465.63	4,620.83	5,776.04	6,007.08	6,145.71	6,238.13	6,376.75	6,931.25	8,086.46	8,317.50	8,548.54
7	2,606.25	3,909.38	5,212.50	6,515.63	6,776.25	6,932.63	7,036.88	7,193.25	7,818.75	9,121.88	9,382.50	9,643.13
8	2,902.08	4,353.13	5,804.17	7,255.21	7,545.42	7,719.54	7,835.63	8,009.75	8,706.25	10,157.29	10,447.50	10,737.71
9	3,197.92	4,796.88	6,395.83	7,994.79	8,314.58	8,506.46	8,634.38	8,826.25	9,593.75	11,192.71	11,512.50	11,832.29
10	3,493.75	5,240.63	6,987.50	8,734.38	9,083.75	9,293.38	9,433.13	9,642.75	10,481.25	12,228.13	12,577.50	12,926.88
11	3,789.58	5,684.38	7,579.17	9,473.96	9,852.92	10,080.29	10,231.88	10,459.25	11,368.75	13,263.54	13,642.50	14,021.46
12	4,085.42	6,128.13	8,170.83	10,213.54	10,622.08	10,867.21	11,030.63	11,275.75	12,256.25	14,298.96	14,707.50	15,116.04
13	4,381.25	6,571.88	8,762.50	10,953.13	11,391.25	11,654.13	11,829.38	12,092.25	13,143.75	15,334.38	15,772.50	16,210.63
14	4,677.08	7,015.63	9,354.17	11,692.71	12,160.42	12,441.04	12,628.13	12,908.75	14,031.25	16,369.79	16,837.50	17,305.21

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	3,325.00	3,740.63	4,156.25	4,571.88	4,987.50	5,403.13	5,818.75	6,234.38	6,650.00	8,312.50	9,975.00	11,637.50
2	4,508.33	5,071.88	5,635.42	6,198.96	6,762.50	7,326.04	7,889.58	8,453.13	9,016.67	11,270.83	13,525.00	15,779.17
3	5,691.67	6,403.13	7,114.58	7,826.04	8,537.50	9,248.96	9,960.42	10,671.88	11,383.33	14,229.17	17,075.00	19,920.83
4	6,875.00	7,734.38	8,593.75	9,453.13	10,312.50	11,171.88	12,031.25	12,890.63	13,750.00	17,187.50	20,625.00	24,062.50
5	8,058.33	9,065.63	10,072.92	11,080.21	12,087.50	13,094.79	14,102.08	15,109.38	16,116.67	20,145.83	24,175.00	28,204.17
6	9,241.67	10,396.88	11,552.08	12,707.29	13,862.50	15,017.71	16,172.92	17,328.13	18,483.33	23,104.17	27,725.00	32,345.83
7	10,425.00	11,728.13	13,031.25	14,334.38	15,637.50	16,940.63	18,243.75	19,546.88	20,850.00	26,062.50	31,275.00	36,487.50
8	11,608.33	13,059.38	14,510.42	15,961.46	17,412.50	18,863.54	20,314.58	21,765.63	23,216.67	29,020.83	34,825.00	40,629.17
9	12,791.67	14,390.63	15,989.58	17,588.54	19,187.50	20,786.46	22,385.42	23,984.38	25,583.33	31,979.17	38,375.00	44,770.83
10	13,975.00	15,721.88	17,468.75	19,215.63	20,962.50	22,709.38	24,456.25	26,203.13	27,950.00	34,937.50	41,925.00	48,912.50
11	15,158.33	17,053.13	18,947.92	20,842.71	22,737.50	24,632.29	26,527.08	28,421.88	30,316.67	37,895.83	45,475.00	53,054.17
12	16,341.67	18,384.38	20,427.08	22,469.79	24,512.50	26,555.21	28,597.92	30,640.63	32,683.33	40,854.17	49,025.00	57,195.83
13	17,525.00	19,715.63	21,906.25	24,096.88	26,287.50	28,478.13	30,668.75	32,859.38	35,050.00	43,812.50	52,575.00	61,337.50
14	18,708.33	21,046.88	23,385.42	25,723.96	28,062.50	30,401.04	32,739.58	35,078.13	37,416.67	46,770.83	56,125.00	65,479.17

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2026 Poverty Guidelines: Hawaii

Dollars Per Year

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	9,180.00	13,770.00	18,360.00	22,950.00	23,868.00	24,418.80	24,786.00	25,336.80	27,540.00	32,130.00	33,048.00	33,966.00
2	12,445.00	18,667.50	24,890.00	31,112.50	32,357.00	33,103.70	33,601.50	34,348.20	37,335.00	43,557.50	44,802.00	46,046.50
3	15,710.00	23,565.00	31,420.00	39,275.00	40,846.00	41,788.60	42,417.00	43,359.60	47,130.00	54,985.00	56,556.00	58,127.00
4	18,975.00	28,462.50	37,950.00	47,437.50	49,335.00	50,473.50	51,232.50	52,371.00	56,925.00	66,412.50	68,310.00	70,207.50
5	22,240.00	33,360.00	44,480.00	55,600.00	57,824.00	59,158.40	60,048.00	61,382.40	66,720.00	77,840.00	80,064.00	82,288.00
6	25,505.00	38,257.50	51,010.00	63,762.50	66,313.00	67,843.30	68,863.50	70,393.80	76,515.00	89,267.50	91,818.00	94,368.50
7	28,770.00	43,155.00	57,540.00	71,925.00	74,802.00	76,528.20	77,679.00	79,405.20	86,310.00	100,695.00	103,572.00	106,449.00
8	32,035.00	48,052.50	64,070.00	80,087.50	83,291.00	85,213.10	86,494.50	88,416.60	96,105.00	112,122.50	115,326.00	118,529.50
9	35,300.00	52,950.00	70,600.00	88,250.00	91,780.00	93,898.00	95,310.00	97,428.00	105,900.00	123,550.00	127,080.00	130,610.00
10	38,565.00	57,847.50	77,130.00	96,412.50	100,269.00	102,582.90	104,125.50	106,439.40	115,695.00	134,977.50	138,834.00	142,690.50
11	41,830.00	62,745.00	83,660.00	104,575.00	108,758.00	111,267.80	112,941.00	115,450.80	125,490.00	146,405.00	150,588.00	154,771.00
12	45,095.00	67,642.50	90,190.00	112,737.50	117,247.00	119,952.70	121,756.50	124,462.20	135,285.00	157,832.50	162,342.00	166,851.50
13	48,360.00	72,540.00	96,720.00	120,900.00	125,736.00	128,637.60	130,572.00	133,473.60	145,080.00	169,260.00	174,096.00	178,932.00
14	51,625.00	77,437.50	103,250.00	129,062.50	134,225.00	137,322.50	139,387.50	142,485.00	154,875.00	180,687.50	185,850.00	191,012.50

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	36,720.00	41,310.00	45,900.00	50,490.00	55,080.00	59,670.00	64,260.00	68,850.00	73,440.00	91,800.00	110,160.00	128,520.00
2	49,780.00	56,002.50	62,225.00	68,447.50	74,670.00	80,892.50	87,115.00	93,337.50	99,560.00	124,450.00	149,340.00	174,230.00
3	62,840.00	70,695.00	78,550.00	86,405.00	94,260.00	102,115.00	109,970.00	117,825.00	125,680.00	157,100.00	188,520.00	219,940.00
4	75,900.00	85,387.50	94,875.00	104,362.50	113,850.00	123,337.50	132,825.00	142,312.50	151,800.00	189,750.00	227,700.00	265,650.00
5	88,960.00	100,080.00	111,200.00	122,320.00	133,440.00	144,560.00	155,680.00	166,800.00	177,920.00	222,400.00	266,880.00	311,360.00
6	102,020.00	114,772.50	127,525.00	140,277.50	153,030.00	165,782.50	178,535.00	191,287.50	204,040.00	255,050.00	306,060.00	357,070.00
7	115,080.00	129,465.00	143,850.00	158,235.00	172,620.00	187,005.00	201,390.00	215,775.00	230,160.00	287,700.00	345,240.00	402,780.00
8	128,140.00	144,157.50	160,175.00	176,192.50	192,210.00	208,227.50	224,245.00	240,262.50	256,280.00	320,350.00	384,420.00	448,490.00
9	141,200.00	158,850.00	176,500.00	194,150.00	211,800.00	229,450.00	247,100.00	264,750.00	282,400.00	353,000.00	423,600.00	494,200.00
10	154,260.00	173,542.50	192,825.00	212,107.50	231,390.00	250,672.50	269,955.00	289,237.50	308,520.00	385,650.00	462,780.00	539,910.00
11	167,320.00	188,235.00	209,150.00	230,065.00	250,980.00	271,895.00	292,810.00	313,725.00	334,640.00	418,300.00	501,960.00	585,620.00
12	180,380.00	202,927.50	225,475.00	248,022.50	270,570.00	293,117.50	315,665.00	338,212.50	360,760.00	450,950.00	541,140.00	631,330.00
13	193,440.00	217,620.00	241,800.00	265,980.00	290,160.00	314,340.00	338,520.00	362,700.00	386,880.00	483,600.00	580,320.00	677,040.00
14	206,500.00	232,312.50	258,125.00	283,937.50	309,750.00	335,562.50	361,375.00	387,187.50	413,000.00	516,250.00	619,500.00	722,750.00

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2026 Poverty Guidelines: Hawaii

Dollars Per Month

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	765.00	1,147.50	1,530.00	1,912.50	1,989.00	2,034.90	2,065.50	2,111.40	2,295.00	2,677.50	2,754.00	2,830.50
2	1,037.08	1,555.63	2,074.17	2,592.71	2,696.42	2,758.64	2,800.13	2,862.35	3,111.25	3,629.79	3,733.50	3,837.21
3	1,309.17	1,963.75	2,618.33	3,272.92	3,403.83	3,482.38	3,534.75	3,613.30	3,927.50	4,582.08	4,713.00	4,843.92
4	1,581.25	2,371.88	3,162.50	3,953.13	4,111.25	4,206.13	4,269.38	4,364.25	4,743.75	5,534.38	5,692.50	5,850.63
5	1,853.33	2,780.00	3,706.67	4,633.33	4,818.67	4,929.87	5,004.00	5,115.20	5,560.00	6,486.67	6,672.00	6,857.33
6	2,125.42	3,188.13	4,250.83	5,313.54	5,526.08	5,653.61	5,738.63	5,866.15	6,376.25	7,438.96	7,651.50	7,864.04
7	2,397.50	3,596.25	4,795.00	5,993.75	6,233.50	6,377.35	6,473.25	6,617.10	7,192.50	8,391.25	8,631.00	8,870.75
8	2,669.58	4,004.38	5,339.17	6,673.96	6,940.92	7,101.09	7,207.88	7,368.05	8,008.75	9,343.54	9,610.50	9,877.46
9	2,941.67	4,412.50	5,883.33	7,354.17	7,648.33	7,824.83	7,942.50	8,119.00	8,825.00	10,295.83	10,590.00	10,884.17
10	3,213.75	4,820.63	6,427.50	8,034.38	8,355.75	8,548.58	8,677.13	8,869.95	9,641.25	11,248.13	11,569.50	11,890.88
11	3,485.83	5,228.75	6,971.67	8,714.58	9,063.17	9,272.32	9,411.75	9,620.90	10,457.50	12,200.42	12,549.00	12,897.58
12	3,757.92	5,636.88	7,515.83	9,394.79	9,770.58	9,996.06	10,146.38	10,371.85	11,273.75	13,152.71	13,528.50	13,904.29
13	4,030.00	6,045.00	8,060.00	10,075.00	10,478.00	10,719.80	10,881.00	11,122.80	12,090.00	14,105.00	14,508.00	14,911.00
14	4,302.08	6,453.13	8,604.17	10,755.21	11,185.42	11,443.54	11,615.63	11,873.75	12,906.25	15,057.29	15,487.50	15,917.71

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	3,060.00	3,442.50	3,825.00	4,207.50	4,590.00	4,972.50	5,355.00	5,737.50	6,120.00	7,650.00	9,180.00	10,710.00
2	4,148.33	4,666.88	5,185.42	5,703.96	6,222.50	6,741.04	7,259.58	7,778.13	8,296.67	10,370.83	12,445.00	14,519.17
3	5,236.67	5,891.25	6,545.83	7,200.42	7,855.00	8,509.58	9,164.17	9,818.75	10,473.33	13,091.67	15,710.00	18,328.33
4	6,325.00	7,115.63	7,906.25	8,696.88	9,487.50	10,278.13	11,068.75	11,859.38	12,650.00	15,812.50	18,975.00	22,137.50
5	7,413.33	8,340.00	9,266.67	10,193.33	11,120.00	12,046.67	12,973.33	13,900.00	14,826.67	18,533.33	22,240.00	25,946.67
6	8,501.67	9,564.38	10,627.08	11,689.79	12,752.50	13,815.21	14,877.92	15,940.63	17,003.33	21,254.17	25,505.00	29,755.83
7	9,590.00	10,788.75	11,987.50	13,186.25	14,385.00	15,583.75	16,782.50	17,981.25	19,180.00	23,975.00	28,770.00	33,565.00
8	10,678.33	12,013.13	13,347.92	14,682.71	16,017.50	17,352.29	18,687.08	20,021.88	21,356.67	26,695.83	32,035.00	37,374.17
9	11,766.67	13,237.50	14,708.33	16,179.17	17,650.00	19,120.83	20,591.67	22,062.50	23,533.33	29,416.67	35,300.00	41,183.33
10	12,855.00	14,461.88	16,068.75	17,675.63	19,282.50	20,889.38	22,496.25	24,103.13	25,710.00	32,137.50	38,565.00	44,992.50
11	13,943.33	15,686.25	17,429.17	19,172.08	20,915.00	22,657.92	24,400.83	26,143.75	27,886.67	34,858.33	41,830.00	48,801.67
12	15,031.67	16,910.63	18,789.58	20,668.54	22,547.50	24,426.46	26,305.42	28,184.38	30,063.33	37,579.17	45,095.00	52,610.83
13	16,120.00	18,135.00	20,150.00	22,165.00	24,180.00	26,195.00	28,210.00	30,225.00	32,240.00	40,300.00	48,360.00	56,420.00
14	17,208.33	19,359.38	21,510.42	23,661.46	25,812.50	27,963.54	30,114.58	32,265.63	34,416.67	43,020.83	51,625.00	60,229.17

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 5

Amendment to Florida's Title XXI Child Health Insurance Plan, Amendment FL-22-00340-CHIP

State of Florida
Florida KidCare Program

Amendment to Florida's Title XXI Child Health Insurance Plan
Submitted to the Centers for Medicare and Medicaid Services

Amendment FL-22-0034-CHIP
March 11, 2021

Florida KidCare

Table of Contents

Tables and Charts

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost sharing imposed on any of the children covered under the plan? **(42CFR 457.505)** Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ YES

8.1.2. ☐ NO**, skip to question 8.8.**

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. ☒ Premiums:

All Florida KidCare program components, except Medicaid, adhere to the same monthly premium provisions. The maximum monthly premium per household is $20 beginning with the payment due July 1, 2003, regardless of

the number of children in the family. Effective with the premium payment due January 1, 2004, the monthly premium per household is $15 for families with income less than or equal to 150% of the federal poverty level and $20 for families with income above 150% to 200% of the federal poverty level. Effective January 1, 2004, for families at or below 150% of the federal poverty level, Florida Healthy Kids is applying $5.00 credits per month for every month the $20.00 premium was paid for coverage during August through December 2003.

Effective January 1, 2014, the income levels for the monthly family premiums changed due to MAGI conversion. The upper income level for the $15 monthly family premium changed from 150% of the federal poverty level (FPL) to 158% FPL. Families with income above 158% FPL to 210% FPL will be charged a $20 monthly family premium. Families with children at different premium levels will be charged the lesser rate for their family premium. This conversion will be implemented effective April 1, 2015 and made retroactive to January 1, 2014. Families will receive correspondence advising them of their new premium payment.

The following table shows the changes in premium levels.

Florida KidCare Family Premiums					
Age	Time Period	$15 Premium		$20 Premium	
		Minimum	Maximum	Minimum	Maximum
1 through 5	Effective 1/1/14	140% FPL	158% FPL	Above 158% FPL	210% FPL
	Prior to MAGI	133% FPL	150% FPL	Above 150% FPL	200% FPL
6 through 18	Effective 1/1/14	133% FPL	158% FPL	Above 158% FPL	210% FPL
	Prior to MAGI	100% FPL	150% FPL	Above 150% FPL	200% FPL

For Healthy Kids and MediKids enrollees with family incomes above 210% (200% FPL prior to MAGI conversion) of the federal poverty level, and therefore not eligible under Title XXI, the family pays a non-subsidized monthly premium on a per child basis.

Families who do not make their monthly premium payments on time will be

disenrolled from coverage and will not be eligible for reinstatement for a minimum of 30 days, in accordance with state law.

Premium payments are due on the first day of the month prior to the month of coverage. Families receive a coupon book upon enrollment that indicates the amount of the monthly premium and the day the premium is due for each month. Families that do not make a premium payment are sent a letter on the 7th of the month informing them that coverage will be cancelled if payment is not received. These letters are followed be a series of automated reminder calls and email reminders. If payment is not received by the 20th of the month a termination letter is issued effective the last day of the month. Families that make payment within the 30-days are issued a reinstatement letter informing them that coverage is still in effect. Premiums are considered late if not received by the first of the month prior to coverage. A 30 day grace period is given to families to make a payment prior to cancellation of coverage.

The late notice is generated by the TPA and also reminds the family that if the premium is not received during the grace period, the child's coverage will be canceled for the next month and a minimum of a 30 day wait before reinstatement would be imposed as required by state law.

On October 7, 2004, the Governor announced temporary changes to the KidCare program to assist families affected by the four hurricanes that impacted the state. The Governor announced that no children would be cancelled due to failure to pay premiums in the aftermath of the storms. The KidCare program adopted a temporary measure to reduce premium payments to $0 for the months of August (for September coverage), September (for October coverage) and October 2004 (for November coverage), for all children enrolled in Title XXI. Any payments received during this period are credited to future months.

Once a month, the TPA sends electronic enrollment files to the Healthy Kids health and dental plans for Healthy Kids enrollees and electronic enrollment files for MediKids to the Agency for Health Care Administration and for the CMSN to the Department of Health. The files include all eligible children who have also made a premium payment by that date. Families who have not paid by this date will receive a second letter indicating that the child's coverage will be canceled at the end of the month and that a minimum 30 day wait will be imposed before coverage can be reinstated if canceled.

A supplemental file is prepared and distributed the first week of the coverage

month that will include the children for whom payment had not been received prior to the previous file but was received within the 30 day grace period.

Additionally, families also have the option of making their monthly family premium payment by credit card. Automated telephone payments were implemented on October 20, 2003, and web payments were implemented effective November 20, 2003. Families may make credit card payments 24 hours a day, seven days a week, either by phone or by accessing the Healthy Kids web site. Families may also arrange to have payment automatically withdrawn (ACH) from their accounts on an ongoing basis.

Beginning in 2010, families have the option of paying their monthly premium by cash. The vendor selected to accept cash payments has hundreds of locations throughout Florida. Families can make their premium payment in person by providing their family account number and their cash payment. The payment is electronically transferred to Florida Healthy Kids Corporation's third party administrator. Another payment option starting in 2011 is for families to pay by text message. Families choosing this payment method are provided an online link to sign up for the service. During the sign up process the family identifies the cell phone number they will be using and the account from which the funds will be deducted and select a personal identification number (PIN). Once enrolled, the family will receive a text message at the beginning of each month reminding them that a payment is due. To make a payment, the family provides their PIN authorizing the payment and deduction from their account. The funds will be automatically withdrawn from their account and the family will receive a text message confirming the payment has been made.

Coinsurance or co-payments:

Healthy Kids

Healthy Kids charges minimal co-payments for some managed care services. Services that require co-payments are listed in the chart below.

Disaster Relief Provisions

At the State's discretion, working collaboratively, and with the agreement of FHKC and/or CMS Plan, the premium due date may be extended or premiums may be waived, in addition, the State may waive or lower copayments for a specific period of time for CHIP enrollees who meet income and other eligibility

requirements and who reside and/or work in Governor or Federally declared disaster areas or state of emergency areas (i.e. pandemic).

8.2.2. ☒ Deductibles:
None of the Florida KidCare components charge deductibles.

Other:

MediKids and CMS : No other cost sharing will be applied.

Healthy Kids: All services are provided by managed care organizations and the following co-payments are applicable.

8.2.3. ☒ Coinsurance or copayments:
Healthy Kids

Healthy Kids charges minimal co-payments for some managed care services. Services that require co-payments are listed in the chart below.

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan, the state assures the following:

COVID-19 Vaccine:
- The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(e)(2) of the Act.

COVID-19 Testing:
- The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

COVID-19 Treatment:
- The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

Coverage for a Condition That May Seriously Complicate the Treatment of

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 6

Audio Transcription: FHKC presentation to Senate Appropriations Committee on Health and Human Services

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*** AUDIO TRANSCRIPTION ***

10/11/2023 Senate Appropriations Committee on Health and Human Services

for 433987-ATS-1037529 TO Senate Appropriations Committee

* * *

Transcribed

By: Stephanie May

Job No.: 433987

CHAIR HARRELL: Now we'll move along. Please let's go on and let's talk further about KidCare. I think we are so excited that the legislature has expanded KidCare and eligibility. We're really looking at the fiscal cliff here and we really would love to hear an update on where we are and really find out how things are moving along. And we hope that we cover as many children as in the state of Florida as possible. Thank you. And you are recognized, Ms. Carr.

MS. CARR: Madam Chair, Vice Chair, committee members, nice to be with you again on a different, slightly, slightly different topic. Now to get us started, I'd first like to go back to the basics on what is Florida KidCare. So Florida KidCare is the brand name representing state-sponsored health insurance for children under age 19.

There are four programs. So Medicaid, Medikids, Florida Healthy Kids, and the CMS plan. There are three main program components. The first would be Medicaid for the lowest income families. Next, for families earning more than Medicaid allows.

There is the Children's Health Insurance Program which is funded jointly by the state and federal dollars.

Parents pay a small monthly premium covering all children in the family. Then for those earning more than CHIP allows, Florida provides the CHIP buy-in program. You may also have heard it called the full pay program. I will say Florida is one of few states that provides this option as a bridge between subsidized and other coverage. There are many other states that do not.

I believe Florida is one of five that provides a full-pay or buy-in program and that is currently offered. It's slightly different between Medikids and Florida Healthy Kids but on average it's $250 per child per month. So as you can see, there is a significant difference between what is owed by a family between CHIP and CHIP buy-in.

We do feel that for the rich benefit package that is child centric provides vision and hearing and mental health benefits as well as dental coverage, that 250 per month per child is competitive in the market. However,

we recognize that there is a drastic cliff in what is charged to families between the two options.

Now we get to House Bill 121 which is a bill benefiting Florida's children. So sponsored in the House by Representative Robin Bartleman here in the senate by Alexis Calatayud. What it does is it increases the CHIP eligibility limit from 200 percent, as you've heard earlier today, up to 300 percent allowing more working families to qualify for coverage.

So one of the things, and I touched on it briefly during our previous presentation, is the idea of this fiscal cliff where families can comfortably afford the nominal charge covering all the children and family, yet if they accept a new job that earns slightly more or even take a promotion of $2 to $3 extra a month or an hour, excuse me, they can end up at a net decrease.

Because what that promotion does is it increases their income above the CHIP eligibility limit and causes them to lose that subsidy. Then when they go to seek other

coverage, that ends up eating the entirety of that bonus and leaving them in the red.

And that is an issue that we've seen in other programs across the state known as the fiscal cliff. And what that really does is it disincentivizes people from seeking upward financial mobility because they choose not to provide upward mobility for their families. They turn down the raises, they don't take promotions, they don't look for new jobs because they cannot afford to lose that subsidy. That's what we're hoping to soften with this bill.

We are creating new premium tiers along a sliding scale hoping to soften that fiscal cliff. And so, of course, the more a family earns, the more they will pay for coverage. Ultimately, the American Community Survey, which is a portion of the Census, estimates that 68,000 Florida children are uninsured within that 200 to 300 percent level.

So to give you an idea of what the income limits look like -- because we hear 200 percent, we hear 300 percent. But what does that actually mean to a family? 200 percent

for a family of two is $39,440. After January 1st, going up to 300 percent, we're looking at close to 60,000. So that's a significant jump for families who can earn up to that much and still qualify for affordable subsidized coverage.

For a family of four, we're going from 60,000 to 90,000. And a family of six, from 80,500 to $120,000. So we're really allowing more room for working families who do have jobs, who are contributing to the economy, who are working but still need a little bit of a hand up to qualify for this coverage.

I mentioned before that there are new premium tiers creating a little bit of a sliding scale to soften that drastic increase. And so, as you can see here, it climbs from 17 to 38 to 64, 194, 130, and 170. One thing to point out is that these will no longer be above 200 percent per child premiums. They will be a premium for the family.

So we're mirroring it to what current CHIP coverage is and extending that to this $170 premium would cover all three children in the house if that's who we have.

Next, to put it all together, this is a chart you may have seen. So you want to start going down the left side, identify your family size, and then walk across from left to right and identify where your income would fall. And that would give you an indication of what your monthly premium would be with this new program.

Now of course we are still continuing to allow that CHIP buy-in or full pay program. It would simply apply to those above 300 percent instead of above 200 percent as current.

Next steps toward implementation. The summer was spent requirements gathering. So we want to make sure that we're looking at our systems front to back identifying all the necessary system changes. Because as we -- as we explained earlier, when you apply online and input all of your information, there's a complex system that works behind the scene to run those numbers and match it to the correct premium and program -- to make sure identifying all the places where that needs to change, get that change, develop our system

plan, and also engage with our state agencies because of course we operate the Florida KidCare program in concert with the Department of Health, ACA and DCF.

So all of us need to make sure that we're working together towards this implementation. The early fall and late summer was message testing and development.

We really sat down and worked with our robust network of community partners to start talking to them about this change and what it means. And these partners really create direct close relationships with people in the field. And so they know -- they've sat down with some of these families who really wanted Florida KidCare coverage but were given a full pay rate and simply couldn't afford it.

And so they're able to now have that list and go back to these families and say please consider Florida KidCare again. There's been some change and we think it really will make sense for your family. We also went and did a significant amount of market research and polling to make sure that we were explaining this in the right way.

Of course we want to make sure that we're meeting people where they are, and that includes terminology. What we've learned is that truly the day to day Floridians do not fully understand what terms like sliding scale or subsidized coverage even means.

So what we found is that income-based is the right term to use to explain our program. So we want to, again, make sure that we're implementing what works for Floridians so that they can fully understand our program and what we have to provide.

We are in testing phases. We're doing internal testing with our third party administrator now. We are also in testing with DCF that started this week actually and we are in preparations to notify current customers. So one very exciting part is that we are able to reach out to many current enrollees in that CHIP buy-in or full-pay program and let them know that they have significant cost savings on the way.

So starting with the payment due in December for January coverage, we're reaching out to them to say, you know, typically you

have paid 250 per month per child, so upwards of sometimes $500, $750. And we're able to let them know that now under this program change, thanks to your commitment to Florida families, they're now only going to pay 170 per month, covering all of those children.

So that will save families, put more money in their pockets, and help generate some economic development.

Next, I want to talk about our communications and outreach perspective. Excuse me. As I mentioned, there are two main audiences here. The current enrollees who we're going to message and let them know that the program has changed to their benefit and that they're going to be cost savings attached to their accounts in a couple of months and also potential enrollees.

Those are children who -- whose parents have applied and turned down coverage because of the cost that they were provided. We want to touch base with them again and let them know to reconsider Florida KidCare. It's those uninsured families within this FPL range.

It's also potentially what we're calling switchers. So individuals who potentially have employer-based coverage now, who might be able to find cost savings through Florida KidCare.

One of the things we've heard when speaking with families is that sometimes with your employer, the actual employee might be able to get free coverage or very low cost, even another 10, 20, $50 to add the spouse. But when you switch to family coverage and you add the children, sometimes that can be an extra $500, $800 or even $1,000, depending on how much the employer is kicking in.

And so even if they were to take advantage of that low cost coverage for themselves and their spouse by splitting off the children, they could net significant savings by choosing to switch their kids to Florida KidCare.

So we have several ways that we're going to get out in the community. One is, again, through our broad network of local partners. Next, we're leveraging our health plans to connect with their community outreach teams in

local communities of high need.

We are also launching a first innovative partnership with CVS pharmacies. They are going to have us -- allow us to do in-store radio PSAs events at select locations. And we're also going to print ads on their prescription bags, letting folks know of this change and to consider Florida KidCare.

Next, here are just some sample advertisements. We're going to make sure that we're tailoring the audience to the best location and language. So in South Florida, we'll run a lot of Creole and Spanish advertisements. Same with the I-4 Corridor. And then English also, of course, throughout.

But we're going to do a robust network of kind of traditional radio campaigns. Also a lot of digital advertising, some digital billboards with some geotracking, and direct mail and a lot of digital advertising as well.

As you can see, we're also doing what you will see as if you read a newspaper. And along the side you get an advertisement for something that's related to an article. It seems strange how they know what you're

interested in. But it's magic. And we're able to place advertisements along the newspapers that parents read most often so we can match the coverage to their interests.

And that was quick. I know we are tight on time for this presentation and I wanted to make sure we had room for questions. But, but I'm sure that completes my slides and I'm ready for questions.

CHAIR HARRELL: Thank you very much. We're open for questions. Well, we do have some public comment. Okay. We have Karen Woodall, Center for Fiscal and Economic Policy. And --

MS. WOODALL: Good morning, Madam Chair, members. And I apologize. This isn't specific to this program, which -- the expansion. Which is great. We support that. It's wonderful. It was kind of -- I want to just to clarify.

I think Senator Davis asked a question about how this disenrollment process would be impacted if we had expanded Medicaid. And the, the expansion of that answer is that it doesn't for children and the medically needy.

But in the part here, Florida Medicaid income limits, parents, caretakers, children, 19 to 20, it says the federal poverty level -- it's a fixed dollar amount. I'm not sure what that means.

But that income eligibility level is very low. It's like 31 percent of the federal poverty level, I believe, with this stuff. So if we had expanded, that would be up to 133 percent of poverty. So those adults who are losing coverage because of being over income would have a significant amount of income that they could continue to make and still qualify for the insurance program.

So I just wanted to add that addition, not miss this opportunity. So thank you. And thank you for having this discussion by the way.

CHAIR HARRELL: Thank you very much. I think this is a very important discussion, especially on the expansion of KidCare. And I'm delighted to hear that there's a major advertising program out there, an outreach to those who, who perhaps would not -- who maybe applied for the full pay and then decided not

to. I think that's a key market we need to look at.

And also, you know, senators, we all have offices, people call our office all the time and we get a lot of questions on Medicaid redetermination. There's a lot of misinformation out there. So I think we all need to be very much apprised of what's going on.

And also for that young lady who was speaking specifically about an individual case, we are the center, you know. We're kind of the bottom of the funnel. All the complaints come to us. So we need to be apprised of, of what is happening and we can assist people. And, and then, you know, had she reached out to any of our offices, I'm sure we could have helped her.

So people need to understand we're there to, to assist in making sure the message on KidCare gets out as also when there's questions on redetermination. But thank you for what you're doing. I'm so excited about KidCare expansion. And I think this will make a big difference for families with children.

And so January 1, we start. Right?

MS. CARR: Yes, ma'am. And we will begin to launch the advertising in earnest at the end of December/start of January because right now, if someone were to apply, they would still be subject to the current cost construction.

And so we want to make sure that we're not confusing folks or creating a level of frustration when they say, "Well, I heard it was cheaper or different. Why am I still getting this higher price tags." We want to really make sure that we're aligning the messaging to begin when it's appropriate for families to apply for that new coverage.

But we are very excited about this as well. We appreciate your commitment to our program and we look forward to what's next.

CHAIR HARRELL: Question. Senator Davis.

MS. DAVIS: Thank you, Chair. Not really a question, just an ask for you. In order to help, I guess like Chair said, in our communities, are there tools that you can send our way so we can help in our social media venues as well to advertise the expansion?

MS. CARR: We would love to. We've put together toolkits for our health plans for our community partners. We'd love to draft some social media posts or even some newsletter articles for those who have newsletters that go out to your constituents. We'd be happy to do that. And I can work with staff to make sure that that gets disseminated around.

CHAIR HARRELL: That's an excellent idea, Senator Davis. And I would encourage you to do kind of something we could put on our, our Facebook pages, we could send out texts, any kind of digital media that we could use to put in our networks out to families. I think that would be very beneficial. We want to get the word outs best as possible.

MS. CARR: Certainly.

CHAIR HARRELL: So I think that is it, senators. Is there any further business to come before the committee? Seeing none, Senator Burton moves. We rise. We adjourn. We are adjourned.

(End of audio recording.)

CERTIFICATE OF TRANSCRIPTIONIST

I, STEPHANIE MAY, do hereby certify:

That said audio transcription is a true record as reported by me, a disinterested person.

I further certify that I am not interested in the outcome of said action, nor connected with, nor related to any of the parties in said action, nor to their respective counsel.

IN WITNESS THEREOF, I have hereunto set my hand this 2nd day of January, 2026.

Stephanie May

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 7

Audio Transcription: Joint AHCA/FHKC presentation House Select Committee on Health Innovation

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*** AUDIO TRANSCRIPTION ***

10/16/23 House Select Committee on Health Innovation

for 433987-ATS-1037529 TO Health Innovation

* * *

Transcribed

By: Stephanie May

Job No.: 433987

CHAIR TUCK: Which brings us to today. Part of our legislative role is to make sure that bills are implemented correctly and the way we intended. So we must ensure the state agencies implement those in a timely manner.

We are joined today by Austin Knoll, deputy secretary for Medicaid policy, quality and operations, and Kim Smoak, the deputy secretary for the Healthcare policy and oversight, both with the Agency for Healthcare Administration. And they will present a briefing on the implementation of several bills from last year and the years prior, as well as the Medicaid plan procurement.

And in addition, we are joined by Ashley Carr, who is the chief marketing officer for Florida Healthy Kids Corporation, who will join AHCA in presenting the briefing of HB 121. Before we start, members, please hold your questions until the very end and we'll have a chance to ask all of our questions to all three presenters at the end. Mr. Knoll, Ms. Smoak, you are recognized.

MR. KNOLL: Good afternoon, Chair Tuck and committee members. I am Austin Knoll and

I have the privilege of serving as one of the deputy secretaries at the Agency for Healthcare Administration. I am before you today with Kim Smoak, my counterpart and deputy secretary, as well as Ashley Carr, chief marketing officer at Healthy Kids, to provide an update on various activities within the agency.

Before diving in to the updates, I'd like to spend just a few moments to provide an overview of the agency. The Agency for Healthcare Administration, also known as AHCA, is focused on its mission to achieve better healthcare for all Floridians.

We accomplish this through three core functions. First, we serve as the state's chief health policy and planning entity. Second, we are charged with administering the Florida Medicaid program. And third, we oversee the licensure and regulation of nearly 50,000 healthcare facilities in the State of Florida. And we do all of this by leveraging technology to support these core functions as well as the rest of agency operations.

Now, at the agency, we emphasize our

objectives by being one agency, one team, or one AHCA. And we do this through three outcomes or three objectives. First, attempting to be cost effective by leveraging the buying power that Florida has to deliver high quality care at a low cost to taxpayers. Second is being transparent. We promote transparency and empower customers to make well-informed decisions.

And third but not least is high quality. We emphasize quality in all things that we do and we always want to put the individual first. As far as updates today, we're going to talk about a number of initiatives that were passed last session as well as one that was passed a few sessions ago. First one is on House Bill 121. That'll be between myself and Ashley Carr, the chief marketing officer.

The next is that I will then touch on House Bill 967 related to the coverage of continuous glucose monitors before diving into the pilot program for individuals with developmental disabilities, which is a joint effort between the agency and the agency for persons with disability.

And last, I will cover statewide Medicaid managed care procurement process and that update covering both our managed care plans as well as our dental plans before handing it off to Ms. Smoak to cover House Bill 763.

So diving into House Bill 121 is the Florida KidCare Program eligibility. But first, I want to give a little bit of context as to what is CHIP. As this is a new committee, I felt this was an appropriate place to start.

The Children's Health Insurance Program, or CHIP, provides coverage to low income children who make too much or their families make too much to qualify for Medicaid. This is a jointly funded program by federal and state dollars. And in Florida, it is operated through a partnership between three state agencies, the Agency for Healthcare Administration, Department of Children and Families, the Department of Health, and Florida Healthy Kids Corporation, which is a nonprofit organization.

Within the agency or AHCA, we are the lead agency for CHIP. You may also hear the

term title 21. That's the Social Security funding mechanism that is leveraged for CHIP. And AHCA works with the federal government to make sure that the Florida KidCare Program follows all the federal laws and rules.

Florida Healthy Kids Corporation is responsible for determining CHIP eligibility as well as administering the Healthy Kids insurance portion of the program. With that, Ashley Carr is up here. We're going to jump back and forth. So I'm going to hand it off to Ashley.

MS. CARR: Good afternoon, Chair Tuck, Vice Chair Lopez, select committee members. Again, Ashley Carr, representing the Florida Healthy Kids Corporation. It's a pleasure to be here with you today. So in keeping with what my colleague at AHCA said, Children's Health Insurance Program represents the state of Florida's option for low income families who earn more than what the Medicaid income thresholds allow.

So if you earn too much for Medicaid, you'll move into CHIP where families pay a small monthly premium that covers all of the

eligible children in the household with one premium. Once you move out of the eligibility criteria for CHIP, so you earn too much, you can go into our CHIP buy-in program, also known as full pay, which allows for similar benefits to families that make too much to qualify for the subsidy.

Families pay a per-child premium on average about $250 per child per month. So as you can see, that's a significant change, going from a small monthly premium covering all of the children in the household and up to 250 per child per month. An effort that the legislature worked to help correct this session, and we'll talk about in a couple of slides.

But I do want to point out that Florida is one of a very few states, I think five, that have opted to create this full pay or buy-in program that provides a bridge between subsidized and full pay coverage. So many states do not offer anything after CHIP. You would simply have to find your own private marketplace plan. I'll hand it back to the deputy secretary.

MR. KNOLL: Thank you, Ashley. And as she alluded to, House Bill 121 made a few changes. First, it increased the income eligibility for children in the CHIP program, increased from 200 percent to 300 percent. Putting that in dollars for a family of four, 200 percent is about $60,000. At 300 percent, it's about $90,000. It also introduced an increase in the number of premium tiers.

Today there are two at $15 and $20 and, and the bill introduced up to six. That way a family would glide off the program rather than just immediately move from subsidized to full pay. All of this with an effective date of January 1, 2024. And turning it back to Ashley.

MS. CARR: Soon, I'll just start elbowing him out of the way. As he mentioned earlier, we did create new premium tiers offering a sliding scale to, to soften what we're calling that fiscal cliff. And that fiscal cliff represents the loss of the subsidy by earning just a few extra dollars.

One of the things we found anecdotally in speaking with our families with that feedback

loop is sometimes it's the difference between $1 or $2 extra per hour per year.

This is not a significant job change. This is a simple promotion. And unfortunately, sometimes because of that loss of the subsidy, you'll get shifted into our full pay option or look at signing onto an employer-based program which could eat up that entire difference. So you could end up being negative because the loss of the subsidy takes up every single ounce of that promotion and you end up with less money.

And so what we want to be able to do is give these families a hand up, meaning that the more a family earns, the more that they contribute. But it allows them to crawl up that cliff rather than just dropping off. And when you look at the American Community Survey, which is a function of the US census, that is an estimate, around 68,000 Florida children who are uninsured with incomes between that 200 and 300 percent. So that's our prime target for this bill.

To put it into perspective, as the deputy secretary mentioned, at 200 percent, a family

of two, so a single parent and child, can earn currently around just under 40,000. That jumps up to nearly 60. Currently a family of four is at 60, that jumps to 90. A family of six, 80 and a half, up to nearly 121,000. So as you can see, a great number of Florida families are going to gain access to this affordable coverage through House Bill 121.

So you can see we created new monthly premium tiers. And as you can see, starting at the top and going down, you'll start at the lowest premium tier at $17, go to 38, 64, 94, 130, and 170. We will continue to offer that CHIP buy-in or full pay plan. It would simply be eligible for those above that 300 percent mark, whereas it's above 200 percent currently.

Putting it all together in one single slide, you'll start by walking down the left side to determine your household size. Then you'll walk across to identify the closest income to your family. And that's an estimation of what the monthly premium would be for Florida KidCare coverage.

And one of the interesting points that I

don't think we've yet mentioned that is key to this bill is we're shifting from a per-child premium to that family coverage mirroring current CHIP. So instead of paying 190 -- or excuse me, 94, 130, or 170 per child, that will now shift and cover all eligible children in the family which could result for current full pay families who fall within this threshold.

If you have three children, you could be paying upwards of $750 currently which we do feel is competitive compared to what some employer-based options cover. However, you will see significant immediate changes going all the way down to $170 covering all of your kids in one fell swoop starting January 1st. Next, back to Austin.

MR. KNOLL: Thank you, Ashley. So in order to accomplish this, there are a few things that have to take place. First, as Ashley just covered, the establishment of new tiers and premiums. Next, we have to work with our partners, both at Florida Healthy Kids and the Department of Children and Families to make appropriate system changes.

And additionally, changes to CHIP are negotiated by the agency with the federal centers for Medicaid and Medicare services or also known as CMS. With all of that, there's system testing and everything going forward for an effective date of January 1. Ashley.

MS. CARR: So as you can see and as was mentioned before, there are several steps toward implementation. The summer post session was spent requirements gathering. Of course we have a complex system behind the scenes that works to make sure when a family applies. And they give us their income deduction and household size information that our system correctly reports the right program placement and premium amount.

So we're marking all of the system changes that need to take place for this to happen effectively and efficiently. That also includes our work with our state agencies. As the deputy secretary mentioned, Florida Healthy Kids is one of four partners. So we work with the Agency for Healthcare Administration, the Department of Children and Families, and the Department of Health.

This bill will touch each one of those agencies. So we worked over the summer to make sure we engaged with each of those state partner agencies to make sure we were singing from the same sheet of music and we all mirrored the same necessary system changes to ensure that we all can hit go on January 1st. During the late summer and early fall, we worked on message testing and development.

We have a broad statewide network of partners in the Florida KidCare program to help create those community local bonds and help those who need a little bit of extra assistance provide one on one application coverage. We worked with those partners as well as doing in depth market research and polling to ensure that we were bringing the right message to the right people.

For example, with the anecdotal story I shared earlier, what we're hoping to showcase to Florida families is that they can take advantage of low cost employer coverage which is offered many times for free or very low cost. Even adding the spouse is $50 or $100. Yet when you make the switch to family

coverage and add your children, that's when your coverage can skyrocket to $800 or $1000 depending on how much your employer kicks in for that, that family side of coverage.

We want to present a new option where mom and dad can stand on employer-based coverage, take advantage of those discounts, move their kids to Florida KidCare, sometimes resulting in hundreds of dollars of savings each month that can be saved or injected back into the economy.

Now we are in testing and deployment phase. We're testing internally with our own third-party administrator to make sure our system is working. We're also working daily in concert with the Department of Children and Families to make sure that their Medicaid eligibility system is making the same changes.

We're testing them singularly and testing them together and testing them front to back starting applications to make sure that the right Information hits the right system at the right time to produce the right result. We also, as I mentioned, have the joy of letting current customers know in the next month or

two that their premiums will perhaps be drastically going down.

And we're very excited to give a Christmas surprise and a little bit of a Christmas bonus to those families.

Next, we look at communications and outreach with two main audiences. As I shared, we have current enrollees and we have potential enrollees. Those potential enrollees are three main buckets, the uninsured population I referred to earlier, that's 68,000, those who are on employer-based coverage, and those who are potential switchers from other based plans.

So as I mentioned, we did a significant amount of market research to make sure that we were presenting the right information. That market research said that above anything else, above access to primary care doctors, adequate networks, deductibles, cost is where you have to drive the communications. They want to know transparently what is their monthly cost, what is their out of pocket cost. So that is where we focused our marketing and communications efforts.

Next, how are we going to get the word out? Again, we're going to leverage our statewide network of community partners which include everything from children's hospitals, health clinics, food banks, libraries, anything in between. We welcome all of you to also help support the efforts through any communications you have with your constituents, be it newsletters or social media posts.

They're also leveraging our contracted health plans to share information. We are also launching a special new partnership with CVS pharmacy and we're going to run some in-store PSAs across the state. We're going to do select events in locations where we have high rates of uninsured, which are the three South Florida counties which is expected, as well as Hillsborough and Orange.

Of course, the higher the population, proportionally, you would expect the higher number of uninsured kids. And we're also going to print ads on their prescription bags to help spread the word.

Next, here's just some sample

advertisements in various platforms. We will do display ads which you'll see on your top left with those unique ads. Anytime you Google something like Ford, all of a sudden when you're reading a newspaper ad on Florida politics or anywhere else, you're seeing ads for Ford trucks and you wonder how they found out. That's the joy of marketing.

We're also doing social media advertising as well as search engine optimization ads as well. And with that I will turn it back to Deputy Secretary Knoll for the next bill.

MR. STEELE: And this is completely off topic of what we were just talking About. So earlier you were talking about families of, of two, four, or six. Does that include the parents?

MR. KNOLL: The Children's Health Insurance Program's specifically targeted to just the children. So from a insurance perspective, we're providing that to the kids. When we're talking family size, you have to use a family size for determinations. And so it would include family, parents or any other dependents that are living in the household.

MR. STEELE: The same household?
MR. KNOLL: Yes.
MR. STEELE: Okay. Thank you.
CHAIR TUCK: Move over to this side real quick. Ranking Member Casello, you're recognized.
MR. CASELLO: Thank you, Chair. Just a couple of quick questions. On HB 121, the community outreach, you've kind of made a, a pact with CVS pharmacies. How about other pharmacies getting on board with that? Is that possible? Like Publix and Walmart and so many of them out there now. Is that something that would be considered?
MR. KNOLL: I'm going to turn that to Ashley.
MS. CARR: Thank you for the question. We welcome all partnerships. We have this unique ability with CVS through existing relationships. However, we would welcome the opportunity to work with Walmart, Walgreens, Publix, any of the others. What we have found is that CVS is the most used within our population, and so that's why they were targeted as being the most popular within our

arena. However, we would certainly be open to engaging with the others. Absolutely.

MR. CASELLO: Thank you, Chair.

CHAIR TUCK: Follow-up?

MR. CASELLO: You know, these are great. These are going to take some kind of manpower hours to implement and follow up on. And I'm sure we'll all have much -- a lot more questions once that's implemented. But my question is, do you have the staff to implement these and see it through?

MR. KNOLL: Thank you, Chair. Yes. Representative, we -- in any bill that is -- comes through, we do, as part of our bill analysis, look at staffing impacts and potential needs from the agency. So we believe that with these initiatives, we have the resources at this time.

MR. CASELLO: One last one, Chair.

CHAIR TUCK: Sure.

MR. CASELLO: Thank you, Chair. My last one. We -- this is strictly for the children. We, we -- about what age is a child not considered a child anymore? How -- what's the age they have to come off this.

MS. CARR: We say through the end of age 18. So you can be on within your 18th year but on roughly your 19th birthday is when you would seek other coverage.

MR. CASELLO: Thank you, Chair.

CHAIR TUCK: Representative Alvarez, you're recognized.

MR. ALVAREZ: Thank you, Madam Chair. Thank you for the presentation. While I was looking at it, I was trying to remember if I had been in the legislature when I saw the patient safety culture surveys. I wrote this down. So I looked it up and I wasn't. Thank God because I was like, "Come on. I'm not that old." 2020 is when it passed. So my question comes, how come it took so long to implement?

MS. SMOAK: Sure. Thank you. Thank you for -- so, you know, I'm not going to stand up here and make excuses. You know, in March of 2020, during session, when this passed, we all know what was going on.

You know, me and my team, it was all hands on deck. You know, we did have the, you know, public health emergency. Although the

state public health emergency expired in June of 2021, we did have the federal public health emergency that just expired in May of this year. Again, not making any excuses. You know, I do take responsibility for the length of time it took us to pass that.

Keep in mind, what we were asked to do through this bill was very different than what we have historically had to do. It did take some manpower. It's a very onerous system that we're having to work with, you know, trying to figure out, you know, working with the ARC system and then adding the additional two, you know, in addition to rulemaking. We all know rulemaking does take some time.

It didn't take us that long. But what took us the longest time, getting the, the meat of the requirements down. Again, I'm not making any excuses, just telling you honestly how it all played out.

MR. ALVAREZ: Okay. Thank you.

CHAIR TUCK: Representative Andrade, you're recognized.

MR. ANDRADE: Thank you, Chair. And on the topic of the, the safety culture surveys,

do you have an estimated deadline of when the new survey results will be published?

MS. SMOAK: Thank you. At this moment -- so we -- starting in January 2025, it will be opened for hospitals and ASCs to register. So we will help get them registered. So in June -- June 1st of 2025 opens registration, registration. So they'll be able to report. So they can go back to 2023 and 2024 data to, to put in.

So once that's in, we would probably estimate they have from June -- I think it was June to August -- to report us the data. Then we probably estimate another six to nine months maybe to compile it and then to post it on aggregate data. You're going to call me back then at that time and ask me that? Just to be -- I just want to be sure before I commit my staff but we, we will work, work on that.

CHAIR TUCK: Representative Rizo. Follow-up?

MR. ANDRADE: Well, I'll be termed out by then. So you're safe.

MS. CARR: I don't know. You can call

me. I'll come over. We can visit.

MR. ANDRADE: But in looking at the AHCA platform and then ARC's platform, the, the data that's currently being collected by ARC is -- I know it's not complete. But is there a plan on, on -- I don't know -- spidering that over to AHCA's platform to, to start kind of creating that baseline of comparison when AHCA starts collecting that data versus ARC?

MS. SMOAK: No, Representative. There, there is not. We will just be starting clean.

CHAIR TUCK: Good. Representative Rizo, you're recognized.

MR. RIZO: Thank you, Chair. And thank you all for all that information. My question is about surveys and 763. So what if a hospital completes a survey in spring of '23 and the other one completes a survey 2025 -- spring of 2025? Is there a way for consumers to kind of compare that information?

MS. SMOAK: Not necessarily because it will be aggregate data. But, but I will make sure to ask my technical folks that question and get that information back to you. Standing here today, I do not believe that

there is. But I will ask our team.

CHAIR TUCK: Follow-up?

MR. RIZO: Follow up. So I would say, you know, why not align it? Why not align the survey and the reporting of it so that people could take a look at it?

MS. SMOAK: That's a, a very valid point. I definitely will, will take that back to our technical team.

MR. RIZO: Thank you.

MS. SMOAK: Thank you for making that.

MR. RIZO: Thank you.

CHAIR TUCK: Good.

MR. RIZO: Good.

CHAIR TUCK: Vice Chair Lopez, you're recognized.

MS. LOPEZ: Thank you, Madam Chair. So my -- sorry. My question is also on House Bill 763. So I looked on slide 33 and you say that the initial reporting period will be sometime in the summer of 2025. Right? Between June 1st and August 31st. And I guess my question is why are you giving the hospitals five years to comply with the law?

MS. SMOAK: So -- thank you. So, you

know, I, I did kind of address a little bit of that earlier. I'm not making excuses, you know, through the -- we did have the public health emergency. It did take us a little time because, you know, working with the, the ARC system, being able to figure that system out, that's a very different system.

We have not used to working with that system in addition to adding our additional questions that we needed to add, and also working with both sets of the 300 plus hospitals, 400 plus ambulatory surgery centers to allow folks time because they had to build their systems too in order to report this data to us.

CHAIR TUCK: Follow-up?

MS. LOPEZ: So is it ready to go now? Sounds like you've spent a good three years getting everybody up and running and for all the obvious reasons. Is it good -- is it ready to go now?

MS. SMOAK: Well, we -- we've allowed that additional time to 2025 for the hospitals and ASCs to make sure they have systems ready to go. I can't 100 percent answer you that

question that it's live and ready to go right now. You know, we, we set it up so that in January 2025, hospitals and ASCs will be able to register. There are some things that we are still fine tuning, if that helps.

MS. LOPEZ: Just the last follow up. So could you provide the committee just -- of all the hospitals and the ambulatory surgical centers, how many of them are ready to go now? How many of them are waiting? I mean, I'd like to -- I just simply would like to know. I mean, yes, you've given them this very nice runway, but that doesn't escape the fact that the law was passed in 2020.

I understand that you had things you had to do. But my God, 2025 is two years down the road -- 18 months down the road. So I, I feel like maybe you could find out who's, who's on top of it and who's not and let us know.

MS. SMOAK: I can do that. Thank you.

CHAIR TUCK: Representative Tramont, you're recognized.

MR. TRAMONT: Thank you, Madam Chair. So my question may be a little bit in the weeds and might require a follow-up get together to

go and -- go into depth on it. But it's not really in the weeds. It's real life for a lot of people.

So I go back to your slide on statewide prepaid dental program reprocurement. I, I think that was during the, the presentation on individuals with disabilities. And if I'm not, then it still prompted a question for me. I want to know what the access is like for folks within that population because there are a lot of folks that are having to drive hours to be able to receive dental care.

Special needs dental care is a -- is, is a hot button right now. So what, what are we doing to, to provide better access to that?

MR. KNOLL: Thank you Representative for that question. And it ties to both. So we have a statewide dental -- prepaid dental plan procurement that's going on as well as what we are trying to accomplish with the developmental disabilities pilot program as well. So within the, the pilot program, we are working with the Agency for persons with disability to make sure we understand what those needs are.

Things like acclimation visits for individuals where they can go in and become more comfortable at the dental facility. We do have time and distance requirements on our dental carriers today that we hold all of the plans accountable to and as well as looking at those standards and those requirements in the upcoming procurement.

As to the actual specifics, happy to sit down with you and walk through what all of those standards are.

CHAIR TUCK: Follow up, Rep. Good. Representative Rayner, you're recognized.

MS. RAYNER: Thank you so much, Madam Chair. This is going to be on HB 763. And so I pulled up the bill and I just kind of want some clarification. On page 4, line 83 of the bill, it talks about that the information will be -- the survey results will be -- for each facility will be published in the aggregate. And I wanted to kind of clarify something that you said when -- in your presentation.

So you talked about the survey results will be reported in the aggregate. Will it be reported in aggregate across the board or will

it be reported in the aggregate per facility? I just -- I wanted to get that clarification.

MS. SMOAK: That is some of the details that we are still working out. But we are reporting it aggregately.

CHAIR TUCK: Follow-up?

MS. RAYNER: Thank you, Madam Chair. So is that aggregately across the board or aggregately for the specific facility?

MS. SMOAK: It's, it's going to be publicly -- I'm sorry. It's going to be publicly available accurately by facility.

CHAIR TUCK: Follow-up?

MS. RAYNER: Actually, no. I don't have a follow up. Thank you.

CHAIR TUCK: Okay. Representative Williams, recognized.

MS. WILLIAMS: Thank you, Madam Chair. When the original solicitation for vendors was responded, it was issued during the summer. It included a proposal plan to change the way that automatically enrollment for Floridians for the disabilities development area. This was to opt out instead of opt in. Was that the intent?

MR. KNOLL: Thank you, Representative, for that question. Yes, the language that we placed in the -- in the procurement was intentional.

CHAIR TUCK: Follow-up?

MS. WILLIAMS: Thank you. It, it was the intent. Is it still the intent? And how was that decision made?

MR. KNOLL: Representative, I'll have to take back exactly the process in making the decision. I know through a number of decisions, the agency looked at past experiences from families determining how we could best provide services to individuals.

And so different decisions were made related to focusing on the individual and providing the best services for those individuals. With respect to the specific item, I'll have to take that back.

CHAIR TUCK: Follow-up?

MS. WILLIAMS: Thank you. On the following up of that, I want to make sure what I'm understanding, that those decisions was made without the direction and the approval from the legislators.

MR. KNOLL: Representative, for a number of different initiatives and other things, there are -- there's guidance through statute or other mechanisms from the legislature and then through decisions that are delegated to the agencies, not just AHCA, but others, to then effectuate those changes in the most effective way possible.

So it's -- I think the intent was not to overstep the legislature in any way, shape, or form. It was merely looking at the individuals and health outcomes and identifying opportunities to better serve Floridians.

CHAIR TUCK: Follow-up?

MS. WILLIAMS: Thank you. Just an easy one. I don't remember exactly who, but they spoke of a surprise for Christmas, January 1. Are we on task for January 1? And if not, where are we making the changes so that we will meet the approval on January 1?

MS. CARR: Thank you for the question. Yes, ma'am. We're in testing phase and on target to launch January 1st.

CHAIR TUCK: Good. Representative

Steele.

MR. STEELE: Thank you, Chair. I've got, like, a four-prong question but it's all related.

CHAIR TUCK: You're recognized for a series. How about that?

MR. STEELE: It's all related to the same thing. So I apologize. I'm a numbers guy and I'm just trying to figure out. So we've got roughly 4.5 million patients that are on Medicaid going to the dental, dental side of the house. It's my understanding that 18 percent is an adoption rate. So only 18 percent of the people that are on, on the dental plan actually use it out of that 4.5 million patients.

And I just wanted to know what the PMPM is that we're paying for dental care for the entire subset and then the, the difference in, you know, the 90 or 82 percent that are not using it.

MR. KNOLL: Thank you, Representative. Thank you for that question. So with dental being carved out, the PMPM that is paid or the per member, per month, if you're not familiar

with that term, is paid differently based off of different stratifications of enrollees. And so first for the -- we pay out the amount to the managed care plans themselves and then we have a separate payment for dental plans.

So we only pay for -- we pay for our members but they are all held to utilization requirements, achieve saving rebates, and like. So there is a maximum that -- or in essence the plans would be returning funds if they do not have utilization or other elements of that.

As far as the 18 percent, some of our populations are not eligible for dental. I'd have to follow up with exactly which populations are and are not. I don't have that with me. And then as far as a total dollar amount, I don't have the exact PMPM but it is in the slides. Let me find you the slide number here.

For dental, the total amount for the entire six years is estimated to be about two to three billion dollars. Compare that to the managed care is between 120 and 150 billion dollars over the six -- same six year period.

MR. STEELE: Just one question. So, so I, I believe the 18 percent is, is -- of the ones that are eligible, only 18 percent actually use the current two plans that we have in the state or that are available under, under the plans. How much of that money that we -- because I'm assuming that we pay in, in advance before we realize the utilization. How much of that did we carve back from those plans that, that didn't have utilization?

MR. KNOLL: I'll have to take that back, Representative. Our third cohort, the third deputy who is overall of the financial aspects, I know would be happy to meet with you or I will and provide that information.

CHAIR TUCK: And Mr. Knoll, if you wouldn't mind getting the committee the PMPM numbers. I think that would be super helpful for all of us. Thank you.

MR. STEELE: I think it's $9.

CHAIR TUCK: It sounds good. Well, thank you, Representative Steele.

MR. KNOLL: I knew it was less than 10. But --

CHAIR TUCK: All right. I counted two.

Do you still have two more? Good, good to go? Okay. Sounds good. Representative Alvarez, you're recognized.

MR. ALVAREZ: Thank you, Madam Chair. I have one question in 96 parts and three subsections.

MS. RAYNER: I'm leaving.

MR. ALVAREZ: ReallyT, this is a follow up to Representative Tramont's question because it occurs to me that if we have dental care but we don't make access to dental care easy or available, then we don't have dental care that's worthy of being called such. And then we're failing our, our people. Are we failing our people?

And then is there -- is price structure -- I mean, I'm, I'm not trying to put you too much on the spot, you know. I, I don't want you to get in trouble. But if you gotta drive three hours, two hours, one hour for your special needs kid to get dental care or even regular care -- and if I remember last year we started funding repayment of loans to get dentists in rural areas.

Are we paying people enough to

participate in Medicaid dentists? Enough to -- should we -- I mean, is maybe an advice point for us to revisit that to increase the amount we reimburse them? Is that part of your structure and analysis? I think there's a question in there.

MR. KNOLL: I will -- I will attempt to answer that. So several years ago, the dental program was carved out from the managed care program where the intent was that we would be able to put an increased amount of pressure on dental carriers, prepaid dental plan plans, to then incentivize them to create the necessary access that we would need.

And so through doing that, we moved away from a fee for service model that -- where the state would establish premiums for what -- the services we would provide to that per member per month fee that we see in managed care. And through that it's also establishing the networks and everything there. And so when -- as the agency, we are charged with enforcing that and making sure that those networks are -- that the plans are meeting those networks and that individuals have access to care.

You know, from an individual provider choice, there's always their own business decisions and options to select or not select different carriers to provide even in the commercial space. They do that for different reasons.

And so I'm a father of three, I understand what it's like to -- even from a commercial Standpoint, trying to find appointments with dental insurances can be challenging. But it all depends on the network. It depends on how we're holding them accountable. And I'll say that our team is dedicated to holding them to the highest of standards through that process.

MR. ALVAREZ: You think we could do a better job?

MR. KNOLL: I believe in any system, there's always opportunity for improvement.

MR. ALVAREZ: All right. So let me follow -- ma'am, let me follow up with this. If I ask you how I can help you or what recommendations you have of me to increase the accessibility of dental care, what would you tell me? What tools do you need?

MR. KNOLL: I would like some -- an opportunity to take that back, give you a more detailed answer and happy to meet with you and discuss those ideas.

MR. ALVAREZ: I would like that. But don't, don't forget me.

CHAIR TUCK: Representative Gonzalez Pittman, you're recognized.

MS. PITTMAN: Thank you, Madam Chair. Okay. It is our fiduciary responsibility to the taxpayers to get the best bang for our buck. Are you looking at high quality low cost providers? Are you all collecting data that you could provide us to determine who are our high quality low cost providers?

MR. KNOLL: Thank you, Representative, for the question. We do collect quite a bit of data on encounters, claims and the like. We also measure various outcome-based measurements.

I mentioned earlier the physician incentive program that targets and looks at the providers that are meeting those quality standards as well as we -- internally, we will look at that from a cost but the idea is to

then reimburse them at a higher level to incentivize for that highest quality to maximize that bang for your buck, if you will.

There's a similar program also in the dental space that's rolling out that also is targeting the same mechanisms.

CHAIR TUCK: Follow-up?

MS. PITTMAN: So if I were to contact Magellan -- going back to my vendor question and the rebates. If I were to contact Magellan, Magellan could provide me with the data to show the savings that we're getting in rebates based on different pharmaceuticals?

MR. KNOLL: Thank you for that question. The specific rebates per drug, there are certain circumstances where that might be confidential or trade secret. I would have to look back and figure out which and what aspects of that. But just because the manufacturers themselves hold that as proprietary information.

CHAIR TUCK: Follow-up?

MS. PITTMAN: So there's no way of knowing the savings that we're getting based on the, the rebates?

MR. KNOLL: IWe do have that information and our -- and we present that in different financial reports that we have available. And happy to provide those to you.

MS. PITTMAN: Thank you.

CHAIR TUCK: Good. Representative Williams, you're recognized.

MS. WILLIAMS: Thank you, Madam Chair. Under this pilot program, will the waiver service provider that contracts with the management care services plan be paid the same rate as the provider outside of the pilot program?

MR. KNOLL: I appreciate the question, Representative. I do not know the answer. I'll have to work with the Agency for Persons with Disability to get that answer for you. And we'll have a joint response for you.

MS. WILLIAMS: Thank you.

CHAIR TUCK: All right. Representative Tramont, you're recognized.

MR. TRAMONT: Thank you, Madam Chair. I was trying to avoid a follow-up and save it for the time, but Representative Alvarez kind of inspired me to dig a little deeper. So as

it pertains -- again, coming back to dental care for folks with special needs.

So I have a friend, nonverbal child, eight years old, boy, needed massive care, had to have root canals, teeth extraction, all in one punch, but 100 percent nonverbal. So he, he has to be put under if he's going to get any type of care. So it took, took quite a while.

You know, you, you, you found a person that actually could -- that would do procedures and do all that, but they wouldn't put him under. So now you had to work with anesthesiologists in order to get that thing required. Now an average person is not going to have the ability to make phone calls that somebody else may be able to make.

So what are we doing to coordinate everybody involved in that? You know, what's happening with, with addressing situations like that? Because that's a very big -- very big deal when it comes to that population. They're not going to just sit there with their mouth open and allow somebody to work in there. They've got to be put under. So can

you -- can you speak to that?

MR. KNOLL: Thank you, Representative, for the question. One of the arms we mentioned was the Department of Health. They manage a program called the Children's Medical Services Network.

And as part of that program, they provide an extra level of care coordination for the families to help align and make those appointments and help the family make it to those appointments, as well as anything that the family needs to feel comfortable during that process.

Additionally, we are looking at how do we treat ambulatory surgical centers where maybe dental services can be provided rather than just going into the hospital or -- and a greater access to care for those individuals as well. So a couple different ways that we're tackling that problem.

CHAIR TUCK: Follow up?

MR. TRAMONT: Follow-up. Thank you, Madam Chair. So I'm going to be very respectful and, and, and friendly as I -- as I can. That's a great answer that there, there,

there appears to be avenues to, to make sure that people get the care. But I'll tell you, the real world, that ain't happening.

So my question is now what are the accountability measures to make sure that happens? Because I understand things fall through the cracks all the time. For this population, nothing should ever fall through the cracks. So what are we doing to prevent things from falling through the cracks for these, these people?

MR. KNOLL: First, you know, recognize the real world, there are some -- things happen, things fall through the crack and that's unfortunate anytime that happens. Again, as a father of three, my youngest has a number of challenges as well that I've witnessed it firsthand. My wife has a debilitating medical condition.

Also understand challenges that individuals and families face with -- when you have medical challenges. And what we are doing is actively working on -- like the managed care from Medicaid, we're working with Department of Health to establish new

procurement terms and contract terms.

Those contract terms have been enforced by Department of Health and they -- and we can walk you through exactly what those provisions are required as well as how that performance has measured over the last several years as well as we're recognizing we're in the development stages of that contract to look at opportunities to strengthen accountability and transparency.

CHAIR TUCK: Follow-up?

MR. TRAMONT: Just a final comment. Thank you for being willing to take the fire. It's a passionate issue for a lot of people. So nothing's directed personally but you're representing the system right now that we all want to fix because everybody in this room is directly impacted by everything that, that you helped oversee. So thanks for being here. I look forward to follow-up.

CHAIR TUCK: Representative Rayner, you're recognized.

MS. RAYNER: Thank you. And I will now have my mic on as I actually ask a question. I wanted to go to SB 2510, the managed care,

and wanted to kind of talk through the pilot program. It's been described as voluntary. Obviously there are some limited funds with regard to it.

And so -- and as we have folks that are on the wait-list for services, I guess I -- the, the example that kind of comes to mind is that we're saying to people on the wait-list, if you live in Miami-Dade or Hillsborough county and you want to get off the wait-list, you must enroll in managed care. Is that the correct framing of kind of where we're at right now?

MR. KNOLL: So just to make sure we're, we're on the same page on this. So the, the waiver program is giving that comprehensive services that may even go a step beyond the home and community based services, long term care services, and the like that go above and beyond just managed care.

For those that are Medicaid eligible, if they chose to opt in, they could be on the managed care today, regardless of being in one of those regions. Right? And then what it's doing is providing that comprehensive services

and it'll be a voluntary process for them to choose if they want to join or be a part of it.

We're still working with the agency for persons with disability on, on how we're going to conduct that outreach and targeting individuals that are on a higher category of care, if you will, on the wait-list to ensure that we are maximizing the opportunity for individuals.

CHAIR TUCK: Follow-up?

MS. RAYNER: Yes. Thank you, Madam Chair. And so, so I'm clear, just for the record, while it is voluntary, what you're saying is that if you want to get off the wait-list, you do not have to be enrolled in managed care. Is that what I'm hearing?

MR. KNOLL: So, Representative, the, the participation in this particular waiver is that it is managed care-directed. So it would be participating in managed care. So to be a part of the waiver, it, it must be managed care, yes.

CHAIR TUCK: All good?

MS. RAYNER: Yeah.

CHAIR TUCK: Perfect. Members, that's the end of my list. Any additional questions? Okay. Seeing none. Thank you all so much for being here. We really appreciate the presentation and, and for taking a lot of our questions. So thank you all so much.

MR. KNOLL: Thank you.

CHAIR TUCK: Members, that's just a, a glimpse of what we're going to do in this committee, this session. So I'm really looking forward to working with you all. It sounds like we all are very passionate about the issue. And, and I'm looking forward to the, the discussions here. And seeing no further agenda. With that, Representative Chamberlain (phonetic) moves. We rise. Objection. Meeting's adjourned.

(End of audio recording.)

CERTIFICATE OF TRANSCRIPTIONIST

I, STEPHANIE MAY, do hereby certify:

That said audio transcription is a true record as reported by me, a disinterested person.

I further certify that I am not interested in the outcome of said action, nor connected with, nor related to any of the parties in said action, nor to their respective counsel.

IN WITNESS THEREOF, I have hereunto set my hand this 2nd day of January, 2026.

Stephanie May

S

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 8

Letter from Angela D. Garner, Deputy Dir. for Dir. Div. of System Reform Demonstrations, Center for Medicaid & CHIP Servs., to Tom Wallace, Deputy Sec'y for Health Care Finance and Data, AHCA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

March 8, 2024

Tom Wallace
Deputy Secretary for Health Care Finance and Data
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Deputy Secretary Wallace:

Thank you for your application for a new section 1115(a) demonstration, entitled "Children's Health Insurance Program (CHIP) Eligibility Extension." The Centers for Medicare & Medicaid Services (CMS) received Florida's request on February 23, 2024. We have completed a preliminary review of your request in accordance with the transparency and public notice procedures specified in 42 CFR 431.412(a) and determined that the state's application does not meet certain requirements for a complete initial demonstration application.

The specific elements that are missing from the state's application that are needed in order for CMS to determine that the request is complete are outlined in the attached enclosure. At this time, CMS will not begin our 30-day federal public comment and notice process as specified under 42 CFR 431.416(b). After the state submits a revised demonstration application that includes the missing elements as described in the enclosure, CMS will conduct another review of the state's submission to determine if the revised request is complete. The state is not required to repost the revised application for another state public comment period before resubmitting it to CMS.

We look forward to working with you and your staff and are available to provide technical assistance as you revise the state's demonstration application. If you have any questions regarding this correspondence, please contact your CMS project officer, Ms. Jamie John, at Jamie.John@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Jason Weida, Secretary, Florida Agency for Health Care Administration
Austin Noll, Deputy Secretary for Medicaid Policy, Florida Agency for Health Care Administration
Kia Carter-Anderson, State Monitoring Lead, Medicaid and CHIP Operations Group

ENCLOSURE

Federal application procedures at 42 CFR 431.412(a)(1) specify the content required for a complete initial demonstration application and specify that the state must comply with the public notice process set forth in 42 CFR 431.408. In accordance with these requirements, below is a list of transparency procedures or application elements that are necessary for the submission of a "complete" section 1115 demonstration request which were not included in the state's section 1115 demonstration application:

1. In accordance with 42 CFR 431.408(a)(1)(i)(C) and 431.412(a)(1)(iii), the application must include the state's *historic* enrollment and expenditures for the demonstration period. The draft application posted for public notice and comment and the final application submitted to CMS had insufficient historic enrollment data, as the graph in the application only depicted historic enrollment for Healthy Kids, which is one component of Florida's KidCare (CHIP) program. The draft and final applications also did not include any historic expenditure data for the KidCare program. The state must provide historic enrollment and expenditure data for the entire KidCare program.

2. In accordance with 42 CFR 431.412(a)(1)(iv), the application must include the state's *current* enrollment data. The draft application posted for public notice and comment and the final application included enrollment data for the KidCare program as of January 2023. The state must provide current enrollment data for the KidCare program that was available at the time of application submission.

3. In accordance with 42 CFR 431.412(a)(1)(viii), the application must include a report of the issues raised by the public during the comment period and how the state considered these comments when developing the demonstration application. The summary of the public comments in the state's application is too broad and does not provide sufficient detail to understand the issues raised by the public. The state must provide a detailed description of the comments or submit all the comments received by the state to CMS.

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 9

Letter from Lisa Marunyez on behalf of Deputy Dir. for Dir. Div. of System Reform Demonstrations, Center for Medicaid & CHIP Servs., to Tom Wallace, Deputy Sec'y for Health Care Finance and Data, AHCA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

March 28, 2024

Tom Wallace
Deputy Secretary for Health Care Finance and Data
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Deputy Secretary Wallace:

The Centers for Medicare & Medicaid Services (CMS) received Florida's request for a new section 1115(a) demonstration, entitled "Children's Health Insurance Program (CHIP) Eligibility Extension," on March 20, 2024. We have completed a preliminary review of your request and have determined that the state's application is complete in accordance with section 42 CFR 431.412(a).

Florida's application will be posted on Medicaid.gov for a 30-day federal comment period as required by 42 CFR 431.416(b). The state's request will be available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

We look forward to working with you and your staff on this application. If you have questions regarding the section 1115 review process, please contact your CMS project officer, Ms. Jamie John, at Jamie.John@cms.hhs.gov.

Sincerely,

Lisa Marunycz, Deputy Director for
Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Jason Weida, Secretary, Florida Agency for Health Care Administration
Austin Noll, Deputy Secretary for Medicaid Policy, Florida Agency for Health Care Administration
Kia Carter-Anderson, State Monitoring Lead, Medicaid and CHIP Operations Group

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 10

Letter from Chiquita Brooks-Lasure, Adm'r, Centers for Medicare and Medicaid Servs. (CMS), to Brian Meyer, Deputy Sec'y for Medicaid, AHCA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

December 2, 2024

Brian Meyer
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Deputy Secretary Meyer:

The Centers for Medicare & Medicaid Services (CMS) is approving Florida's section 1115(a) demonstration titled, "Florida Children's Health Insurance Program Eligibility Extension" (Project Number 21-W-00076/4). Approval of this demonstration will allow the state to increase the income eligibility threshold of its separate title XXI Children's Health Insurance Program (CHIP) (known in the state as the Florida KidCare Program or KidCare) from 210 percent of the federal poverty level (FPL) to up to, and including, 300 percent of the FPL. This threshold increase specifically applies to children aged 1 through 18 who qualify for these components of Florida's separate CHIP: MediKids, Florida Healthy Kids, and Children's Medical Services. The demonstration is effective as of the date of this letter and will expire on September 30, 2029.

Extent and Scope of the Demonstration

With this approval, Florida will have the authority to raise the CHIP income eligibility threshold, therefore expanding eligibility under the Florida KidCare Program to children aged 1 through 18 with family incomes above 210 percent of the FPL and up to, and including, 300 percent of the FPL. Any reduction in the eligibility limit would require submission of a formal amendment as described in the special terms and conditions (STCs).

The state will also have the authority to require enrollees in the CHIP expansion population (i.e., children aged 1 through 18 with a household income ranging above 210 percent of the FPL and up to, and including, 300 percent of the FPL) to pay a monthly premium, consistent with what is allowable under the CHIP state plan. CMS is approving Florida's request to charge premiums to the CHIP expansion population that vary depending on a household's income. Table 1 shows the premium tiers by household FPL level in the first year of the demonstration period. The premiums for the CHIP expansion population must comply with the statutory requirements related to maintenance of effort under section 2105(d)(3)(A) of the Social Security Act ("the Act").

Table 1. CHIP Monthly Premiums for the Florida KidCare Expansion Population

210.01 – 235.00% FPL	235.01 – 255.00% FPL	255.01 – 275.00% FPL	275.01 – 300.00% FPL
$60	$95	$145	$195; $145 for a household size of 1*

*Individuals with income between 275.01 – 300.00 percent of the FPL and with a household size of 1 are subject to a lower premium to ensure the 5 percent cost sharing cap will not be exceeded.

In addition, the premiums and cost sharing amounts combined cannot exceed five (5) percent of a household's income.[1] Consistent with CHIP state plan requirements, Florida will have the authority to increase these CHIP premiums annually by applying inflation adjustments that are based on (and no more than) the percentage increase in the Consumer Price Index (CPI) trended forward using the applicable CPI: Medical care inflation rate (or another state specific index submitted by the state and approved by CMS). After applying inflation adjustments, the premiums and cost sharing amounts combined still cannot exceed five (5) percent of a household's income. Florida must submit a CHIP state plan amendment to revise the premiums for households with income above 133 percent of the FPL and up to, and including, 210 percent of the FPL.

Beginning January 1, 2024, pursuant to the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117- 328)A, states are required to provide twelve (12) months of continuous eligibility for Medicaid and CHIP coverage to children under age 19.[2] The CHIP expansion population in this demonstration is also subject to 12 months of continuous eligibility. The CAA, 2023 prohibits disenrollment of the expansion population for nonpayment of premiums during the 12-month continuous eligibility period.[3] Even if the CAA, 2023 did not prohibit disenrollment for failure to pay premiums, CMS would impose the same condition in this demonstration as a matter of policy in order to promote access to care and continuity of coverage. It has been found that individuals with continuous health coverage are more likely to be in better health, less likely to

[1] Section 2103(e)(3)(B) of the Social Security Act.

[2] Section 5112 of the CAA, 2023 amended sections 1902(e)(12) and 2107(e)(1) of the Social Security Act to add this requirement.

[3] After enactment of the CAA, 2023, the Medicaid statute's continuous eligibility requirement applies to CHIP "in the same manner" as it applies to Medicaid, where states are not permitted to terminate coverage based on nonpayment of premiums during the continuous eligibility period. *See* Section 5112(a) of the CAA, 2023 (amending the Medicaid statute to require that a "State plan . . . shall provide" that children "determined to be eligible for benefits under a State plan" generally "shall remain eligible for such benefits" for a 12-month period); 42 C.F.R. § 435.930(b) (providing that states "must . . . [c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible); 42 C.F.R. § 435.926(d) (providing that a "child's eligibility" for Medicaid "may not be terminated during a continuous eligibility period" unless one of five exceptions is met); Section 5112(b) of the CAA, 2023 (amending the CHIP statute to provide that, with one exception, the continuing eligibility requirement in section 1902(e)(12) of the Medicaid statute, as amended by the CAA, 2023, "shall apply to States under this title [i.e., CHIP] in the same manner as they apply to a State under title XIX [i.e., Medicaid]"). CMS has published a final rule explaining this requirement. *See* CMS, Department of Health & Human Services, *Medicare and Medicaid Programs:…Medicaid and CHIP Continuous Eligibility (Nov. 1, 2024),* https://www.federalregister.gov/public-inspection/2024-25521/medicare-and-medicaid-progr[…]al-outpatient-prospective-payment-and-ambulatory-surgical

forgo needed medical care, and more likely to develop patient-provider relationships.[4] This condition is reflected in the STCs.

CMS has determined that this demonstration as approved is likely to assist in promoting the objectives of CHIP, as it will provide access to comprehensive health coverage for low-income children who would otherwise not be covered under the state's CHIP. Florida estimates that an additional 41,874 children will be eligible for KidCare with this expansion by demonstration year (DY) 5.

CHIP Allotment

Under this demonstration, the state will be subject to a limit on the amount of federal title XXI funding that the state may receive on allowable demonstration expenditures during the demonstration period. CMS has long required, as a condition of demonstration approval, that demonstrations be "allotment neutral," meaning the federal title XXI funds for the state's CHIP are restricted to the state's available allotment and reallocated funds. The state is eligible to receive title XXI funds for the demonstration population as described in STC 4.1, up to the amount of its title XXI allotment. Title XXI funds must be first used to fully fund costs associated with CHIP state plan populations. The demonstration expenditures are limited to remaining funds. The state is required to comply with all existing rules for operating within the available CHIP allotment and, as necessary, requesting an increase in allotment. In requiring demonstrations to be allotment neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of CHIP and its interest in facilitating state innovation and coverage through section 1115 demonstration approvals.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and robust independent evaluation of the demonstration in alignment with the STCs. Throughout the life cycle of the demonstration approval period, monitoring will help track the state's progress towards its demonstration goals. The state must develop a comprehensive Evaluation Design to assess whether the demonstration is effective in producing the desired outcomes for its beneficiaries as well as the state's Medicaid and CHIP programs overall. Evaluation of the demonstration must assess the impact of expanding eligibility for CHIP, including the premium requirement, on beneficiary enrollment, access, and health outcomes. The state's monitoring and evaluation efforts must facilitate understanding the extent to which the demonstration might support reducing existing health disparities.

Consideration of Public Comments

[4] Brantley, E., & Ku, L. (2022). Continuous eligibility for Medicaid associated with improved child health outcomes. Medical Care Research and Review, 79(3), 404-413.; Brooks T, Gardner A. (2021). Continuous Coverage in Medicaid and CHIP. Georgetown University Health Policy Institute. https://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf; Fox, J. B., & Richards, C. L. (2010). Vital Signs: Health Insurance Coverage and Health Care Utilization--United States, 2006-2009 and January-March 2010. MMWR: Morbidity & Mortality Weekly Report, 59(44).; Smith, D. A., Akira, A., Hudson, K., Hudson, A., Hudson, M., Mitchell, M., & Crook, E. (2017). The effect of health insurance coverage and the doctor-patient relationship on health care utilization in high poverty neighborhoods. Preventive Medicine Reports, 7, 158-161.

The federal comment period was open from March 29, 2024, through April 28, 2024, and received 13 comments. One comment was unrelated to Florida's demonstration request. The majority of the comments explicitly expressed support for expanding the CHIP eligibility threshold, but many commenters expressed concerns that the premiums for the CHIP expansion population were too costly to be affordable and would create a financial burden for families. Some specifically opposed the premium structure for those at or below 150 percent of the FPL, expressing that they were too expensive. However, CHIP enrollees at or below 150 percent of the FPL are covered by Florida's non-demonstration CHIP state plan and are not impacted by this demonstration. The premiums for the CHIP expansion population align with what is allowable under the CHIP state plan, and the premiums and cost sharing amounts combined cannot exceed 5 percent of a family's income.

Other commenters had concerns that Florida's demonstration conflicted with the CAA, 2023, which they stated prohibits termination from CHIP for non-payment of premiums during the 12-month continuous eligibility period. Commenters said that termination of coverage due to non-payment of premiums could create barriers to accessing care and disruptions in treatment, and that there was insufficient monitoring and evaluation related to disenrollments. CMS believes continuous eligibility is a valuable tool that has the potential to advance access to care and improve health outcomes. Therefore, CMS is not allowing the state to disenroll individuals for non-payment of CHIP premiums during the 12-month continuous eligibility period based on research cited above supporting the importance maintaining continuous eligibility has on health outcomes and ongoing access to care.

One comment noted that the CHIP premiums should consider the number of children in a household so families with one child can pay less than families with multiple children. Another comment suggested removing the income threshold to qualify for the Children's Medical Services program, which is a component of KidCare that is tailored to children with special health care needs, so children with disabilities can have access to better and more affordable insurance options. We thank the commenters for these recommendations, but these decisions are outside the scope of this demonstration review.

After careful review of the information received from the state and the comments submitted during the federal comment period, CMS has concluded that the demonstration is likely to advance the objectives of CHIP.

Other Information

CMS's approval of this section 1115(a) demonstration project is contingent upon compliance with the enclosed expenditure authority, STCs, and any supplemental attachments defining the nature, character, and extent of anticipated federal involvement in this demonstration project. The state may deviate from CHIP state plan requirements only to the extent those requirements have been specifically listed as not applicable under the demonstration. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

The project officer for this demonstration is Ms. Jamie John. She is available to answer any questions concerning implementation of the state's section 1115(a) demonstration and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Jamie.John@cms.hhs.gov

We look forward to our continued partnership on the Florida Children's Health Insurance Program Eligibility Extension demonstration. If you have any questions regarding this approval, please contact Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Chiquita Brooks-LaSure
Administrator

Enclosures

cc: Jason Weida, Secretary, Florida Agency for Health Care Administration
Austin Noll, Deputy Secretary for Medicaid Policy, Quality, and Operations, Florida Agency for Health Care Administration
Kia Carter-Anderson, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 21-W-00076/4

TITLE: Florida Children's Health Insurance Program Eligibility Extension

AWARDEE: Florida Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Florida (referred to herein as the state) for the item identified below, which is not otherwise included as expenditures under section 2105 of the Act, shall for the period from December 2, 2024, through September 30, 2029, unless otherwise specified, be regarded as expenditures under the state's title XXI plan.

This expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Florida to operate the above-identified section 1115(a) demonstration.

All requirements of CHIP expressed in law, regulation, and policy statements, not expressly waived or identified as not applicable to the below expenditure authority, shall apply to the Florida CHIP Eligibility Extension demonstration for the period of this approved demonstration.

Title XXI Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, through September 30, 2029, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the beneficiaries described in demonstration expenditure authority 1.

1. **Expenditures for Florida KidCare Expansion.** Expenditures for all state plan services under the demonstration for individuals ages 1 through 18 who meet all eligibility criteria for CHIP with incomes above 210 percent up to, and including, 300 percent of the federal poverty level (FPL) as described in STC 3.6 and 4.1 who are not otherwise eligible for CHIP coverage as of December 2, 2024.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00076/4

TITLE: Florida Children's Health Insurance Program Eligibility Extension

AWARDEE: Florida Agency for Health Care Administration

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Children's Health Insurance Program (CHIP) Eligibility Extension section 1115(a) CHIP demonstration (hereafter "demonstration") to enable Florida (hereafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authority under section 2105 of the Social Security Act (Act) authorizing federal matching of demonstration costs not otherwise matchable, and which is separately enumerated. These STCs set forth conditions and limitations on the expenditure authority, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the program for those populations affected by the demonstration are effective from December 2, 2024 through September 30, 2029, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Eligibility for the Demonstration
5	Benefits, Cost-sharing, and Delivery System
6	General Financial Requirements
7	Monitoring Allotment Neutrality
8	Monitoring and Reporting Requirements
9	Evaluation of the Demonstration
10	Schedule of State Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Developing the Evaluation Design
Attachment B	Preparing the Interim and Summative Evaluation Reports
Attachment C	Evaluation Design [Reserved]

2. PROGRAM DESCRIPTION AND OBJECTIVES

The Florida CHIP Eligibility Expansion section 1115 demonstration provides title XXI expenditure authority to allow the state to increase the income eligibility threshold in Florida KidCare, the state's CHIP program, from 210 percent of the federal poverty level (FPL) up to, and including, 300 percent of the FPL, as described in STC 4.1. This threshold increase specifically applies to children aged 1 through 18 who qualify for these components of Florida's separate CHIP: MediKids, Florida Healthy Kids, and Children's Medical Services.

During the demonstration period, the state seeks to achieve the following goals:

- Increase enrollment and access to CHIP coverage; and

- Improve or maintain the rate of uninsured children under age 19 in the state.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified allotment neutrality agreement will be effective upon the implementation of the change.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the CHIP state plan governs.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. Any reduction in the CHIP eligibility threshold below the most recently approved threshold will require submission of a formal amendment, as described in STC 3.7. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STCs, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. An up-to-date CHIP allotment worksheet, that reflects the associated costs of implementing the amendment as proposed by the state;

d. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration, in whole or in part, consistent with the following requirements:

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-Out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-Out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-Out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1) or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e) and 42 CFR 457.350, respectively. The state must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to a review consistent with 42 CFR 457.1180. In addition, the state must assure all applicable appeal and

hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221 for Medicaid or 42 CFR 457.1120 through 457.1190 for CHIP. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230 for Medicaid or must ensure the opportunity for continuation of enrollment and benefits in CHIP consistent with 42 CFR 457.1170.

e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid or CHIP eligibility in accordance with the approved Medicaid or CHIP state plan.

g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved CHIP State Plan consistent with section 2107(e)(1)(F) of the Act, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.14. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.15. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.16. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY FOR THE DEMONSTRATION

4.1. **Florida KidCare Eligibility Expansion.** This demonstration increases the CHIP eligibility threshold from 210 percent of the FPL up to, and including, 300 percent of the FPL. The beneficiaries in the Florida KidCare eligibility expansion population, described in expenditure authority 1, will include individuals ages 1 through 18 with a household income ranging from above 210 percent of the FPL up to, and including, 300 percent of the FPL and who meet all other non-financial eligibility criteria for these components of Florida's separate CHIP: MediKids, Florida Healthy Kids, and Children's Medical Services. The expansion population is made eligible by virtue of the expenditure authority expressly granted in this demonstration and is subject to the CHIP laws or regulations except as specified in the STCs and expenditure authority for this demonstration. These cited documents generally provide that all requirements of CHIP laws and regulations do apply, except to the extent waived or specified as not applicable. The criteria for the Florida KidCare Eligibility Expansion population are as follows (Table 1):

Table 1. Expansion Population Affected by the Demonstration

Description	Program	Social Security Act Citation	42 CFR Citation
KidCare Expansion Group – individuals ages 1 through 18 with income above 210 percent up to, and including, 300 percent of the FPL who meet all other CHIP eligibility criteria.	CHIP	2110(b)	457.310

5. BENEFITS, COST SHARING, AND DELIVERY SYSTEM

5.1. **Demonstration Benefits.** Individuals enrolled in this demonstration will receive comprehensive benefits as provided under the CHIP state plan for the separate title XXI program that the individual is enrolled in, whether MediKids, Florida Healthy Kids, or Children's Medical Services.

5.2. **Cost Sharing.** Individuals enrolled in this demonstration will be subject to cost sharing responsibilities, such as monthly premiums and co-pays, to the extent allowable under Title XXI requirements, except as specified in this STC. Premiums will be dependent on a household's FPL and will range from $60 to $195 in demonstration year 1 (see Table 2). The state can increase premiums annually to account for inflation, using the Consumer Price Index (CPI): Medical Care inflation rate or another state-specific index submitted by the state and approved by CMS. Individuals may not be disenrolled from this demonstration for failure to pay the monthly premium during the individual's 12-month continuous eligibility period. The state must notify CMS if the copayment amounts charged under this demonstration will differ from the amounts charged for individuals with income below 210 percent of the FPL under the CHIP state plan, and premiums for the demonstration population must be consistent with what is allowable under the CHIP regulations. The premiums and cost sharing amounts combined cannot exceed an individual's 5 percent cost sharing cap.

Table 2. CHIP Monthly Premiums for the Florida KidCare Expansion Population[1]

210.01 – 235.00% FPL	235.01 – 255.00% FPL	255.01 – 275.00% FPL	275.01 – 300.00% FPL
$60	$95	$145	$195; $145 for a household size of 1[2]

[1]Florida can increase premiums annually by inflation only. The inflation adjustment must be based on (and no more than) the percentage increase in the Consumer Price Index (CPI) trended forward using the applicable CPI: Medical care inflation rate (or another state-specific index submitted by the state and approved by CMS).

[2] Individuals with income between 275.01 – 300.00 percent of the FPL and with a household size of 1 are subject to a lower premium to ensure the 5 percent cost sharing cap will not be exceeded.

5.3. **Delivery System.** Individuals enrolled in this demonstration will receive all applicable CHIP state plan services through a fee-for-service or a managed care delivery system, as described in the CHIP state plan. The managed care delivery system is authorized under other managed care authorities, including the Florida Managed Medical Assistance section 1115 demonstration.

6. GENERAL FINANCIAL REQUIREMENTS

6.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

6.2. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act [cross referenced at section 2107(e)(1)(Q) for CHIP] and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

6.3. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act [cross referenced at section 2107(e)(1)(Q) for CHIP] and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology.

This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 [cross referenced at 42 CFR 457.628(a) for CHIP] it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c) [cross referenced at 42 CFR 457.628(a) for CHIP].

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 [cross referenced at 42 CFR 457.628(a) for CHIP] and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of CHIP payments in a manner inconsistent with the requirements in section 1903(w) of the Act [cross referenced at section 2107(e)(1)(Q) for CHIP] and its implementing regulations. This confirmation of CHIP payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to CHIP and in which there is no connection to CHIP payments, are not considered returning and/or redirecting a CHIP payment.

e. The State Medicaid Director/CHIP Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-21 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

6.4. **Demonstration Years**. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 3. Demonstration Years

Demonstration Year (DY)	Dates	Duration
DY 1	December 2, 2024 to September 30, 2025	10 months
DY 2	October 1, 2025 to September 30, 2026	12 months

Demonstration Year (DY)	Dates	Duration
DY 3	October 1, 2026 to September 30, 2027	12 months
DY 4	October 1, 2027 to September 30, 2028	12 months
DY 5	October 1, 2028 to September 30, 2029	12 months

7. MONITORING ALLOTMENT NEUTRALITY

7.1. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.** The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c. **Premiums**. Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

d. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

7.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

7.3. **Title XXI Administrative Costs.** All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI ten (10) percent administrative cap described in section 2105(c)(2)(A) of the Act.

7.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration population described in STC 4.1 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

7.5. **Exhaustion of Title XXI Funds for CHIP Population.** If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

8. MONITORING AND REPORTING REQUIREMENTS

8.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

In the event that either (1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below, within 30 calendar days after the deliverable was due, or (2) the state has not submitted a revised resubmission or a plan for corrective action to CMS within 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement, including the information needed to bring the deliverable(s) into alignment with CMS requirements, the following process is triggered:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b) above, and the state fails to comply with the corrective action plan or, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

8.2. **Submission of Post-Approval Deliverables.** The state must submit deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

8.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

8.4. **Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each demonstration year (DY). The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments

received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

   Additionally, the demonstration's metrics reporting must cover categories to include, but not limited to: enrollment and renewal, disenrollments, the number of individuals eligible for the demonstration, the number of individuals subject to premiums, and the number of individuals who pay monthly premium payments including at enrollment and renewal.

   The state and CMS will work collaboratively to finalize the list of metrics to be reported on in Monitoring Reports. The required monitoring and performance metrics must be included in the Monitoring Reports and will follow the CMS framework provided by CMS to support federal tracking and analysis. The reporting of the monitoring metrics must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, and geography), to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid or CHIP population, including the narrowing of any identified health disparities.

c. **Allotment Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64 or CMS-21, as applicable. Administrative costs for this demonstration should be reported separately on the Form CMS-64 or CMS-21, as applicable.

d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

8.5. **Compliance with Managed Care, Network Adequacy, Quality Strategy and EQR Reporting Requirements**. The state must comply with all managed care reporting regulations of 42 CFR Part 438, and 42 CFR Part 457 subpart L except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

8.6. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid or CHIP, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing preventive services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

8.7. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 9.7 and 9.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 8.1.

8.8. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, allotment neutrality, enrollment and access, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

8.9. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its Medicaid or CHIP website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

9. EVALUATION OF THE DEMONSTRATION

9.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 8.1.

9.2. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

9.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 9.7 and 9.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

In the event of demonstration extensions, for components that are continuing from the prior demonstration approval period, the state's Evaluation Design must reframe and refocus as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements, and where the demonstration's role might be more to help stabilize outcomes. Likewise, for continuing policies, the state must revisit its analytic approaches compared to those used in the prior approval period evaluation activities, to ensure that the evaluation of those policies taps into the longer implementation time span.

9.4. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

9.5. **Evaluation Design Approval and Updates.** The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid or CHIP website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

9.6. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as enrollment and enrollment continuity, reasons for nonpayment of premiums, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Specifically, evaluation hypotheses must assess the impact of the premium requirement on the outcomes of interest. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of preventive services. Proposed measures should be selected from nationally-recognized sources and national measure sets, where

possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set); Consumer Assessment of Health Care Providers and Systems (CAHPS); and/or measures endorsed by National Quality Forum (NQF).

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, as well as Medicaid or CHIP health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid or CHIP program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the demonstration, and beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography), and by demonstration component, to the extent feasible. Such stratified analyses will provide a fuller understanding of existing health and help inform how the demonstration's various policies might support reducing such disparities.

9.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid or CHIP website with the application for public comment.

a. The Interim Evaluation Report, in alignment with the CMS-approved Evaluation Design, will discuss evaluation progress and present findings to date.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, the draft Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Interim Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid or CHIP website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

9.8. **Summative Evaluation Report.** The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs.

a. The Summative Evaluation Report, in alignment with the Evaluation Design, must evaluate the entirety of the demonstration period.

b. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

c. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid or CHIP website within 30 calendar days.

d. The Summative Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

9.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid or CHIP, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration initiatives, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals,

such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

9.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

9.11. **Public Access.** The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid or CHIP website within 30 calendar days of approval by CMS.

9.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration, over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

10. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Due	Deliverable	STC
30 calendar days after demonstration approval date	State acceptance of demonstration STCs and associated Expenditure Authority	Approval letter
180 calendar days after demonstration approval date	Evaluation Design	9.3
September 30, 2028, or with extension application	Interim Evaluation Report	9.7.c
Within 18 months of the end of the demonstration approval period represented by these STCs	Summative Evaluation Report	9.8
Annual deliverable – due 90 calendar days after end of each demonstration year	Annual Monitoring Reports	8.4
Quarterly deliverable – due 60 calendar days after end of each demonstration quarter	Quarterly Monitoring Reports	8.4
Annual deliverable – due 90 calendar days after end of each demonstration year as part of the annual monitoring report	Allotment Neutrality Reports	8.4
Close-out Report due 120 days after the end of the demonstration	Close-out Report	8.7

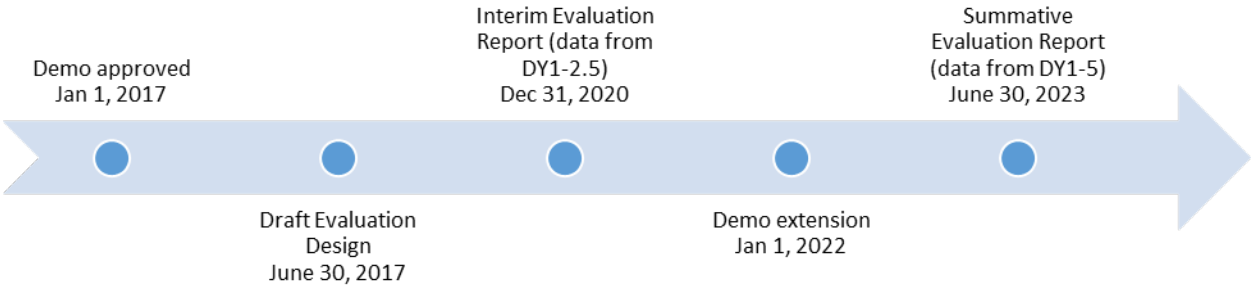
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid or CHIP programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid or CHIP policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, the potential magnitude of the issues, and why the state selected this course of action to address the issues (e.g., a narrative on why the state submitted a section 1115 demonstration application).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.

5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre–test or post–test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid–Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t–tests, chi–square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference–in–differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	–Measure 1 –Measure 2 –Measure 3	–Sample e.g. All attributed Medicaid beneficiaries –Beneficiaries with diabetes diagnosis	–Medicaid fee–for–service and encounter claims records	–Interrupted time series
Research question 1b	–Measure 1 –Measure 2 –Measure 3 –Measure 4	–Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	–Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	–Measure 1 –Measure 2	–Sample, e.g., PPS administrators	–Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to

minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long–standing, it may be difficult for the state to include baseline data because any pre–test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non–complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid or CHIP policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS–64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation–related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

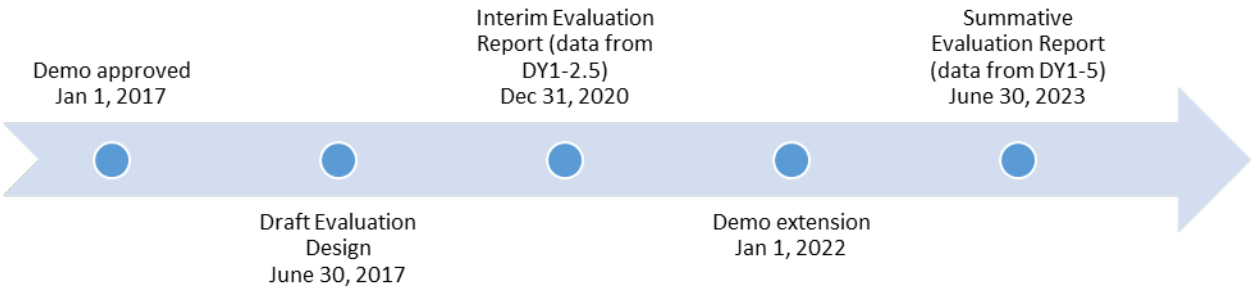
ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid or CHIP programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid or CHIP policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid or CHIP section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already–approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When

conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid or CHIP policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;

I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
    1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, how the state became aware of the issues, the potential magnitude of the issues, and why the state selected this course of action to address the issues.
    2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
    3. A description of the population groups impacted by the demonstration.
    4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
    5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:
    1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
    2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
    3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
    4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published

research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post–only data, with or without comparison groups, etc.

2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected.

4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t–tests, chi–square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration

results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:
    1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    2. If the state did not fully achieve its intended goals, why not?
    3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid or CHIP context and long–range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid or CHIP program, interactions with other Medicaid or CHIP demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid or CHIP. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid or CHIP policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:
    1. What lessons were learned as a result of the demonstration?
    2. What would you recommend to other states which may be interested in implementing a similar approach?

ATTACHMENT C
Evaluation Design [Reserved]

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 11

Email exchange between Bryan Meyer, Deputy Sec'y for Medicaid, AHCA and Daniel Tsai, Deputy Adm'r & Dir., Ctr. for Medicaid & CHIP Servs.

From: Meyer, Brian
Sent: Wednesday, January 15, 2025 7:50 PM
To: Tsai, Daniel (CMS/CMCS) <Daniel.Tsai@cms.hhs.gov>
Cc: Cooper, Jacey (CMS/CMCS) <jacey.cooper@cms.hhs.gov>
Subject: RE: Approval of the Florida Children's Health Insurance Program Eligibility Extension Section 1115(a) Demonstration

Dear Deputy Administrator and Director Daniel Tsai,

The Agency is pleased to accept CMS's proposal, with the following modifications attached. These changes incorporate nearly all of CMS's terms and conditions, with only minor edits to ensure compliance with Florida law. By adopting these modifications, the waiver will align with state law, allowing Florida and CMS to move forward with our shared goal of improving access to health care for the children of Florida.

Thank you,

Brian Meyer | Deputy Secretary for Medicaid
Agency for Health Care Administration
850.412.4115 (office) | 850.815.7960 (mobile)
Brian.Meyer@ahca.myflorida.com

Privacy Statement: This email may include confidential and/or proprietary information and may be used only by the person or entity to which it is addressed. If the reader of this e-mail is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this e-mail is prohibited. If you have received this in error, please reply to the sender and delete immediately.

From: Tsai, Daniel (CMS/CMCS) <Daniel.Tsai@cms.hhs.gov>
Sent: Tuesday, December 31, 2024 5:42 PM
To: Meyer, Brian <Brian.Meyer@ahca.myflorida.com>
Cc: Cooper, Jacey (CMS/CMCS) <jacey.cooper@cms.hhs.gov>
Subject: Re: Approval of the Florida Children's Health Insurance Program Eligibility Extension Section 1115(a) Demonstration

Hi Brian - see below for a response to your email yesterday. Thank you. -Dan

CMS has received your request for an extension, which we understand to be a request for us to reconsider the portion of the STCs addressing the question of disenrollment of the Children's Health Insurance Program expansion population for nonpayment of premiums during the 12-month continuous eligibility period. We see no basis to reconsider either our understanding of the relevant legal authorities or our policy views with regard to this issue. However, we are granting Florida a 14-day extension, until January 15, 2025, to either raise any other issue (not involving continuous eligibility based on failure to pay premiums) for CMS to consider or otherwise respond to CMS's December 2, 2024 letter. We will not grant

further extensions. Unless Florida raises any other issue, Florida should refer back to CMS's December 2, 2024, letter for a statement of CMS's position.

Deputy Administrator Dan Tsai

From: Meyer, Brian <Brian.Meyer@ahca.myflorida.com>
Sent: Monday, December 30, 2024 2:15:03 PM
To: Tsai, Daniel (CMS/CMCS) <Daniel.Tsai@cms.hhs.gov>
Cc: Cooper, Jacey (CMS/CMCS) <jacey.cooper@cms.hhs.gov>
Subject: FW: Approval of the Florida Children's Health Insurance Program Eligibility Extension Section 1115(a) Demonstration

Dear Deputy Administrator and Director Daniel Tsai,

The Agency has received the proposed Special Terms and Conditions (STCs) from the Centers for Medicare & Medicaid Services (CMS) concerning Florida's request for a new Children's Health Insurance Program (CHIP) section 1115(a) demonstration, titled "Florida Children's Health Insurance Program Eligibility Extension." This program could have been approved in its entirety, as submitted by the Agency 9 months ago. Still, your Administration has repeatedly failed to do so, delaying implementation by adding your own conditions outside our submission's scope.

This begs the question of why the Biden administration continues to play games with children's health. CMS is actively choosing to block the implementation of an initiative that supports an essential program that helps families achieve economic self-sufficiency by continuing to add unnecessary conditions.

As you know, once approved, this 1115 demonstration will be implemented under the new incoming Administration without allowing them the ability to review and approve an initiative that will likely impact their time in office. This could prove to be detrimental to the program's future. To ensure a successful implementation, we strongly believe the incoming Administration must have the opportunity to determine the program's terms and conditions.

Because of this, Florida respectfully requests an extension of the 30-day deadline, at least until February 1, 2025. This extension will allow the Agency to work closely with the new Administration to navigate this critical initiative effectively. It is time for the Federal Government to act as our partner in implementing this program and finally end the political meddling. Let's get back to focusing on what matters most: children.

Thank you,

Brian Meyer | Deputy Secretary for Medicaid
Agency for Health Care Administration
850.412.4115 (office) | 850.815.7960 (mobile)
Brian.Meyer@ahca.myflorida.com

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From: John, Jamie (CMS/CMCS) <Jamie.John@cms.hhs.gov>
Sent: Monday, December 2, 2024 4:03 PM
To: Meyer, Brian <Brian.Meyer@ahca.myflorida.com>; Weida, Jason <Jason.Weida@ahca.myflorida.com>; Noll, Austin <Austin.Noll@ahca.myflorida.com>; Dalton, Ann <Ann.Dalton@ahca.myflorida.com>; Sokoloski, Kristin <Kristin.Sokoloski@ahca.myflorida.com>; Owens, Meagan <Meagan.Owens@ahca.myflorida.com>; Quinn, Kimberly <Kimberly.Quinn@ahca.myflorida.com>; Fauci, Suzann <Suzann.Fauci@ahca.myflorida.com>
Cc: Cooper, Jacey (CMS/CMCS) <jacey.cooper@cms.hhs.gov>; Kostesich, Jennifer (CMS/CMCS) <Jennifer.Kostesich@cms.hhs.gov>; Rashid, Mehreen (CMS/CMCS) <mehreen.rashid@cms.hhs.gov>; Decaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Garner, Angela (CMS/CMCS) <Angela.Garner@cms.hhs.gov>; Marunycz, Lisa (CMS/CMCS) <Lisa.Marunycz@cms.hhs.gov>; Trieger, Michael (CMS/CMCS) <Michael.Trieger1@cms.hhs.gov>; Xu, Siqing (CMS/CMCS) <siqing.xu@cms.hhs.gov>; Daly, Danielle (CMS/CMCS) <Danielle.Daly@cms.hhs.gov>; Kazi, Paula (CMS/CMCS) <Paula.Kazi@cms.hhs.gov>; Hill, Elizabeth (CMS/CMCS) <Elizabeth.Hill@cms.hhs.gov>; Smith, Raven (CMS/CMCS) <Raven.Smith@cms.hhs.gov>; Nadeau, Aaron (CMS/CMCS) <Aaron.Nadeau@cms.hhs.gov>; Carter-Anderson, Kia (CMS/CMCS) <Kia.Carter-Anderson@cms.hhs.gov>
Subject: Approval of the Florida Children's Health Insurance Program Eligibility Extension Section 1115(a) Demonstration

Dear Deputy Secretary Meyer and Florida colleagues,

CMS has approved Florida's request for a new Children's Health Insurance Program (CHIP) section 1115(a) demonstration titled, "Florida Children's Health Insurance Program Eligibility Extension." Approval of this demonstration will allow the state to increase the income eligibility threshold of its separate title XXI CHIP from 210 percent of the federal poverty level (FPL) to up to, and including, 300 percent of the FPL, providing more children access to affordable health care. Please see the attached approval letter and the attached expenditure authority and special terms and conditions (STCs) for the demonstration. CMS's approval of this section 1115(a) demonstration is contingent upon compliance with the expenditure authority and STCs.

The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days (no later than Wednesday, January 1, 2025).

Please let us know if you have any questions.

Thank you,
Jamie John

Jamie John
(she/her)

Project Officer
State Demonstrations Group
Centers for Medicare & Medicaid Services (CMS)
Jamie.John@cms.hhs.gov

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 12

Letter from Daniel Tsai, Deputy Adm'r & Dir., Ctr. for Medicaid & CHIP Servs., to Brian Meyer, Deputy Sec'y for Medicaid, AHCA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

January 17, 2025

Brian Meyer
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Deputy Secretary Meyer:

On December 2, 2024, the Centers for Medicare & Medicaid Services (CMS) approved Florida's request for a section 1115(a) demonstration titled, "Florida Children's Health Insurance Program Eligibility Extension" (Project Number 21-W-00076/4). As required under the terms of the December 2 approval letter, Florida was required to submit written acknowledgement of the award and acceptance of the demonstration's special terms and conditions (STCs) by CMS's extended deadline of January 15, 2025, in order to effectuate the demonstration. On January 15, 2025, Florida accepted the demonstration's STCs and included a proposed modification to remove the requirement in STC 5.2 that states "Individuals may not be disenrolled from this demonstration for failure to pay the monthly premium during the individual's 12-month continuous eligibility period."

CMS is unable to accept your requested modification because it does not comply with the statute and implementing regulations for continuous eligibility for children. Sections 1902(e)(12) and 2107(e)(1)(K) of the Social Security Act, as amended by Consolidated Appropriations Act, 2023 specifically apply to coverage under state plan or waiver of the state plan. Additionally, 42 CFR 435.926 and 457.342, with which the demonstration must comply in accordance with STC 3.2 and 42 CFR 431.420(a)(1), make clear that failure to pay premiums is not a permissible exception to continuous eligibility for children.

The state may now implement the demonstration consistent with the STCs approved on December 2, 2024, and must comply with these STCs in full, including STC 5.2, in order to receive federal financial participation.

Daniel Tsai
Deputy Administrator and Director

c: Jason Weida, Secretary, Florida Agency for Health Care Administration
Kia Carter-Anderson, State Monitoring Lead,

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 13

Medicaid.gov, Section 1115 Demonstrations, State Waivers List, Florida Children's Health Insurance Program Eligibility Extension

An official website of the United States government Here's how you know

Florida Children's Health Insurance Program Eligibility Extension

State:	**Florida**
Waiver Authority:	**1115**
Status:	**Approved**

Waiver Dates

Approval:	**12/02/2024**
Effective:	**12/02/2024**
Expiration:	**09/30/2029**

Feedback

Supporting Documents

Approved Application(s) and Related Documents

Administrative Record

12/02/2024	Demonstration Approval (PDF, 583.89 KB)	
03/28/2024	CMS Completeness Letter (PDF, 321.43 KB)	
03/20/2024	State Application – CHIP Eligibility Extension (PDF, 17.29 MB)	View Comments
03/08/2024	CMS Incompleteness Letter (PDF, 306.47 KB)	

« Return to State Waivers List

Related Sites

Data.Medicaid.gov
Healthcare.gov
CMS.gov
InsureKidsNow.gov
HHS.gov
Medicare.gov

Sign up

Your email address

e-mail here

Sign up

Feedback

Helpful Links

Web Policies and Important Links
No Fear Act
Archive
Plain Language
Site Feedback
Nondiscrimination & Accessibility
Privacy Policy
Help with File Formats & Plug-ins

Privacy Settings

Medicaid.gov
Keeping America Healthy

Centers for Medicare & Medicaid Services

A federal government managed website by the Centers for Medicare & Medicaid Services.
7500 Security Boulevard Baltimore, MD 21244

Feedback

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 14

Letter from Karen Llanos, Acting Director, State Demonstrations Group, CMS, to Brian Meyer, Deputy Sec'y for Medicaid, AHCA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

Brian Meyer
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Deputy Secretary Meyer:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Florida Children's Health Insurance Program Eligibility Extension (Project Number 21-W-00076/4) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is updating the cadence for this demonstration to annual monitoring reporting (see also section 1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to

alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on March 30, 2026, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 8.4, "Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

Demonstration Monitoring Calls

As STC 8.8 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the

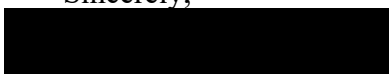
structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Florida Children's Health Insurance Program Eligibility Extension section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,



Karen LLanos
Acting Director

Enclosure
Cc Kia Carter-Anderson, State Monitoring Lead, Medicid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 21-W-00076/4

TITLE: Florida Children's Health Insurance Program Eligibility Extension

AWARDEE: Florida Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Florida (referred to herein as the state) for the item identified below, which is not otherwise included as expenditures under section 2105 of the Act, shall for the period from December 2, 2024, through September 30, 2029, unless otherwise specified, be regarded as expenditures under the state's title XXI plan.

This expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Florida to operate the above-identified section 1115(a) demonstration.

All requirements of CHIP expressed in law, regulation, and policy statements, not expressly waived or identified as not applicable to the below expenditure authority, shall apply to the Florida CHIP Eligibility Extension demonstration for the period of this approved demonstration.

Title XXI Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, through September 30, 2029, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the beneficiaries described in demonstration expenditure authority 1.

1. **Expenditures for Florida KidCare Expansion.** Expenditures for all state plan services under the demonstration for individuals ages 1 through 18 who meet all eligibility criteria for CHIP with incomes above 210 percent up to, and including, 300 percent of the federal poverty level (FPL) as described in STC 3.6 and 4.1 who are not otherwise eligible for CHIP coverage as of December 2, 2024.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00076/4

TITLE: Florida Children's Health Insurance Program Eligibility Extension

AWARDEE: Florida Agency for Health Care Administration

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Children's Health Insurance Program (CHIP) Eligibility Extension section 1115(a) CHIP demonstration (hereafter "demonstration") to enable Florida (hereafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authority under section 2105 of the Social Security Act (Act) authorizing federal matching of demonstration costs not otherwise matchable, and which is separately enumerated. These STCs set forth conditions and limitations on the expenditure authority, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the program for those populations affected by the demonstration are effective from December 2, 2024 through September 30, 2029, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Eligibility for the Demonstration
5	Benefits, Cost-sharing, and Delivery System
6	General Financial Requirements
7	Monitoring Allotment Neutrality
8	Monitoring and Reporting Requirements
9	Evaluation of the Demonstration
10	Schedule of State Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Developing the Evaluation Design
Attachment B	Preparing the Interim and Summative Evaluation Reports
Attachment C	Evaluation Design [Reserved]

2. PROGRAM DESCRIPTION AND OBJECTIVES

The Florida CHIP Eligibility Expansion section 1115 demonstration provides title XXI expenditure authority to allow the state to increase the income eligibility threshold in Florida KidCare, the state's CHIP program, from 210 percent of the federal poverty level (FPL) up to, and including, 300 percent of the FPL, as described in STC 4.1. This threshold increase specifically applies to children aged 1 through 18 who qualify for these components of Florida's separate CHIP: MediKids, Florida Healthy Kids, and Children's Medical Services.

During the demonstration period, the state seeks to achieve the following goals:

- Increase enrollment and access to CHIP coverage; and

- Improve or maintain the rate of uninsured children under age 19 in the state.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified allotment neutrality agreement will be effective upon the implementation of the change.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the CHIP state plan governs.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. Any reduction in the CHIP eligibility threshold below the most recently approved threshold will require submission of a formal amendment, as described in STC 3.7. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STCs, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. An up-to-date CHIP allotment worksheet, that reflects the associated costs of implementing the amendment as proposed by the state;

d. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration, in whole or in part, consistent with the following requirements:

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-Out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-Out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-Out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1) or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e) and 42 CFR 457.350, respectively. The state must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to a review consistent with 42 CFR 457.1180. In addition, the state must assure all applicable appeal and

hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221 for Medicaid or 42 CFR 457.1120 through 457.1190 for CHIP. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230 for Medicaid or must ensure the opportunity for continuation of enrollment and benefits in CHIP consistent with 42 CFR 457.1170.

e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid or CHIP eligibility in accordance with the approved Medicaid or CHIP state plan.

g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved CHIP State Plan consistent with section 2107(e)(1)(F) of the Act, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.14. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.15. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.16. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY FOR THE DEMONSTRATION

4.1. **Florida KidCare Eligibility Expansion.** This demonstration increases the CHIP eligibility threshold from 210 percent of the FPL up to, and including, 300 percent of the FPL. The beneficiaries in the Florida KidCare eligibility expansion population, described in expenditure authority 1, will include individuals ages 1 through 18 with a household income ranging from above 210 percent of the FPL up to, and including, 300 percent of the FPL and who meet all other non-financial eligibility criteria for these components of Florida's separate CHIP: MediKids, Florida Healthy Kids, and Children's Medical Services. The expansion population is made eligible by virtue of the expenditure authority expressly granted in this demonstration and is subject to the CHIP laws or regulations except as specified in the STCs and expenditure authority for this demonstration. These cited documents generally provide that all requirements of CHIP laws and regulations do apply, except to the extent waived or specified as not applicable. The criteria for the Florida KidCare Eligibility Expansion population are as follows (Table 1):

Table 1. Expansion Population Affected by the Demonstration

Description	Program	Social Security Act Citation	42 CFR Citation
KidCare Expansion Group – individuals ages 1 through 18 with income above 210 percent up to, and including, 300 percent of the FPL who meet all other CHIP eligibility criteria.	CHIP	2110(b)	457.310

5. BENEFITS, COST SHARING, AND DELIVERY SYSTEM

5.1. **Demonstration Benefits.** Individuals enrolled in this demonstration will receive comprehensive benefits as provided under the CHIP state plan for the separate title XXI program that the individual is enrolled in, whether MediKids, Florida Healthy Kids, or Children's Medical Services.

5.2. **Cost Sharing.** Individuals enrolled in this demonstration will be subject to cost sharing responsibilities, such as monthly premiums and co-pays, to the extent allowable under Title XXI requirements, except as specified in this STC. Premiums will be dependent on a household's FPL and will range from $60 to $195 in demonstration year 1 (see Table 2). The state can increase premiums annually to account for inflation, using the Consumer Price Index (CPI): Medical Care inflation rate or another state-specific index submitted by the state and approved by CMS. Individuals may not be disenrolled from this demonstration for failure to pay the monthly premium during the individual's 12-month continuous eligibility period. The state must notify CMS if the copayment amounts charged under this demonstration will differ from the amounts charged for individuals with income below 210 percent of the FPL under the CHIP state plan, and premiums for the demonstration population must be consistent with what is allowable under the CHIP regulations. The premiums and cost sharing amounts combined cannot exceed an individual's 5 percent cost sharing cap.

Table 2. CHIP Monthly Premiums for the Florida KidCare Expansion Population[1]

210.01 – 235.00% FPL	235.01 – 255.00% FPL	255.01 – 275.00% FPL	275.01 – 300.00% FPL
$60	$95	$145	$195; $145 for a household size of 1[2]

[1]Florida can increase premiums annually by inflation only. The inflation adjustment must be based on (and no more than) the percentage increase in the Consumer Price Index (CPI) trended forward using the applicable CPI: Medical care inflation rate (or another state-specific index submitted by the state and approved by CMS).

[2] Individuals with income between 275.01 – 300.00 percent of the FPL and with a household size of 1 are subject to a lower premium to ensure the 5 percent cost sharing cap will not be exceeded.

5.3. **Delivery System.** Individuals enrolled in this demonstration will receive all applicable CHIP state plan services through a fee-for-service or a managed care delivery system, as described in the CHIP state plan. The managed care delivery system is authorized under other managed care authorities, including the Florida Managed Medical Assistance section 1115 demonstration.

6. GENERAL FINANCIAL REQUIREMENTS

6.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

6.2. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act [cross referenced at section 2107(e)(1)(Q) for CHIP] and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

6.3. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act [cross referenced at section 2107(e)(1)(Q) for CHIP] and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology.

This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 [cross referenced at 42 CFR 457.628(a) for CHIP] it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c) [cross referenced at 42 CFR 457.628(a) for CHIP].

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 [cross referenced at 42 CFR 457.628(a) for CHIP] and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of CHIP payments in a manner inconsistent with the requirements in section 1903(w) of the Act [cross referenced at section 2107(e)(1)(Q) for CHIP] and its implementing regulations. This confirmation of CHIP payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to CHIP and in which there is no connection to CHIP payments, are not considered returning and/or redirecting a CHIP payment.

e. The State Medicaid Director/CHIP Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-21 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

6.4. **Demonstration Years**. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 3. Demonstration Years

Demonstration Year (DY)	Dates	Duration
DY 1	December 2, 2024 to September 30, 2025	10 months
DY 2	October 1, 2025 to September 30, 2026	12 months

Demonstration Year (DY)	Dates	Duration
DY 3	October 1, 2026 to September 30, 2027	12 months
DY 4	October 1, 2027 to September 30, 2028	12 months
DY 5	October 1, 2028 to September 30, 2029	12 months

7. MONITORING ALLOTMENT NEUTRALITY

7.1. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.** The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c. **Premiums**. Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

d. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

7.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

7.3. **Title XXI Administrative Costs.** All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI ten (10) percent administrative cap described in section 2105(c)(2)(A) of the Act.

7.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration population described in STC 4.1 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

7.5. **Exhaustion of Title XXI Funds for CHIP Population.** If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

8. MONITORING AND REPORTING REQUIREMENTS

8.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

In the event that either (1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below, within 30 calendar days after the deliverable was due, or (2) the state has not submitted a revised resubmission or a plan for corrective action to CMS within 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement, including the information needed to bring the deliverable(s) into alignment with CMS requirements, the following process is triggered:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b) above, and the state fails to comply with the corrective action plan or, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

8.2. **Submission of Post-Approval Deliverables.** The state must submit deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

8.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

8.4. **Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each demonstration year (DY). The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments

received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

   Additionally, the demonstration's metrics reporting must cover categories to include, but not limited to: enrollment and renewal, disenrollments, the number of individuals eligible for the demonstration, the number of individuals subject to premiums, and the number of individuals who pay monthly premium payments including at enrollment and renewal.

   The state and CMS will work collaboratively to finalize the list of metrics to be reported on in Monitoring Reports. The required monitoring and performance metrics must be included in the Monitoring Reports and will follow the CMS framework provided by CMS to support federal tracking and analysis. The reporting of the monitoring metrics must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, and geography), to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid or CHIP population, including the narrowing of any identified health disparities.

c. **Allotment Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64 or CMS-21, as applicable. Administrative costs for this demonstration should be reported separately on the Form CMS-64 or CMS-21, as applicable.

d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

8.5. **Compliance with Managed Care, Network Adequacy, Quality Strategy and EQR Reporting Requirements**. The state must comply with all managed care reporting regulations of 42 CFR Part 438, and 42 CFR Part 457 subpart L except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

8.6. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid or CHIP, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing preventive services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

8.7. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 9.7 and 9.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 8.1.

8.8. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, allotment neutrality, enrollment and access, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

8.9. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its Medicaid or CHIP website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

9. EVALUATION OF THE DEMONSTRATION

9.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 8.1.

9.2. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

9.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 9.7 and 9.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

In the event of demonstration extensions, for components that are continuing from the prior demonstration approval period, the state's Evaluation Design must reframe and refocus as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements, and where the demonstration's role might be more to help stabilize outcomes. Likewise, for continuing policies, the state must revisit its analytic approaches compared to those used in the prior approval period evaluation activities, to ensure that the evaluation of those policies taps into the longer implementation time span.

9.4. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

9.5. **Evaluation Design Approval and Updates.** The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid or CHIP website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

9.6. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as enrollment and enrollment continuity, reasons for nonpayment of premiums, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Specifically, evaluation hypotheses must assess the impact of the premium requirement on the outcomes of interest. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of preventive services. Proposed measures should be selected from nationally-recognized sources and national measure sets, where

possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set); Consumer Assessment of Health Care Providers and Systems (CAHPS); and/or measures endorsed by National Quality Forum (NQF).

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, as well as Medicaid or CHIP health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid or CHIP program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the demonstration, and beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography), and by demonstration component, to the extent feasible. Such stratified analyses will provide a fuller understanding of existing health and help inform how the demonstration's various policies might support reducing such disparities.

9.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid or CHIP website with the application for public comment.

a. The Interim Evaluation Report, in alignment with the CMS-approved Evaluation Design, will discuss evaluation progress and present findings to date.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, the draft Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Interim Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid or CHIP website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

9.8. **Summative Evaluation Report.** The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs.

a. The Summative Evaluation Report, in alignment with the Evaluation Design, must evaluate the entirety of the demonstration period.

b. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

c. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid or CHIP website within 30 calendar days.

d. The Summative Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

9.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid or CHIP, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration initiatives, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals,

such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

9.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

9.11. **Public Access.** The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid or CHIP website within 30 calendar days of approval by CMS.

9.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration, over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

10. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Due	Deliverable	STC
30 calendar days after demonstration approval date	State acceptance of demonstration STCs and associated Expenditure Authority	Approval letter
180 calendar days after demonstration approval date	Evaluation Design	9.3
September 30, 2028, or with extension application	Interim Evaluation Report	9.7.c
Within 18 months of the end of the demonstration approval period represented by these STCs	Summative Evaluation Report	9.8
Annual deliverable – due 90 calendar days after end of each demonstration year	Annual Monitoring Reports	8.4
Quarterly deliverable – due 60 calendar days after end of each demonstration quarter	Quarterly Monitoring Reports	8.4
Annual deliverable – due 90 calendar days after end of each demonstration year as part of the annual monitoring report	Allotment Neutrality Reports	8.4
Close-out Report due 120 days after the end of the demonstration	Close-out Report	8.7

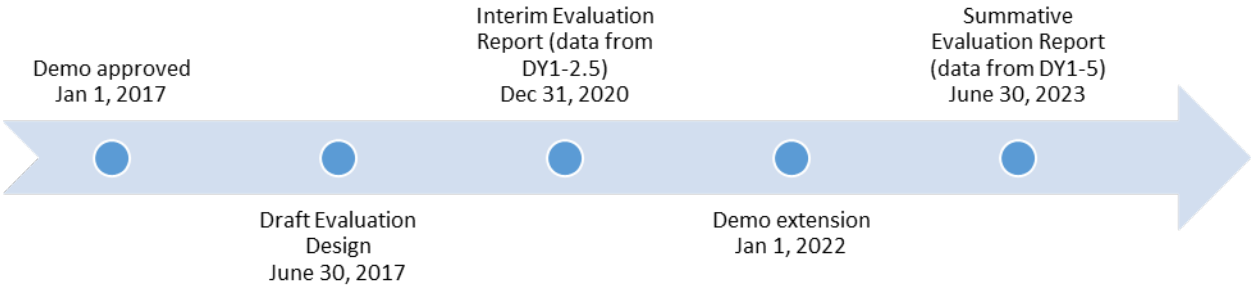
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid or CHIP programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid or CHIP policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, the potential magnitude of the issues, and why the state selected this course of action to address the issues (e.g., a narrative on why the state submitted a section 1115 demonstration application).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.

5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre–test or post–test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid–Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t–tests, chi–square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference–in–differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	–Measure 1 –Measure 2 –Measure 3	–Sample e.g. All attributed Medicaid beneficiaries –Beneficiaries with diabetes diagnosis	–Medicaid fee–for–service and encounter claims records	–Interrupted time series
Research question 1b	–Measure 1 –Measure 2 –Measure 3 –Measure 4	–Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	–Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	–Measure 1 –Measure 2	–Sample, e.g., PPS administrators	–Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to

minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long–standing, it may be difficult for the state to include baseline data because any pre–test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non–complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid or CHIP policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS–64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation–related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

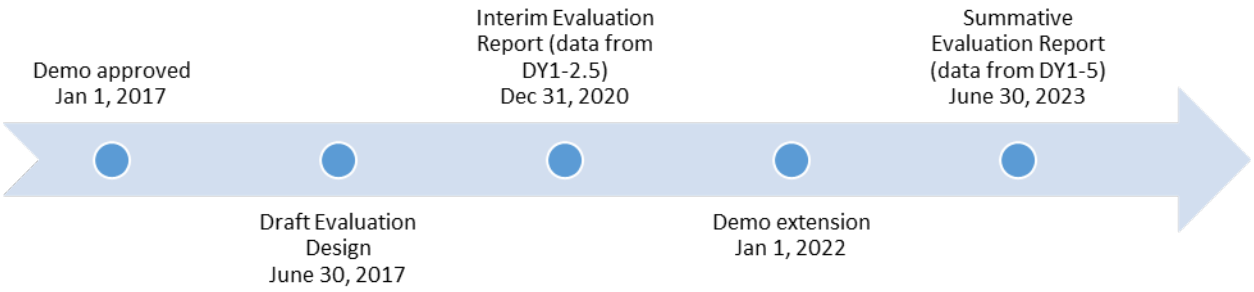
ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid or CHIP programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid or CHIP policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid or CHIP section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already–approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When

conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid or CHIP policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;

I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
    1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, how the state became aware of the issues, the potential magnitude of the issues, and why the state selected this course of action to address the issues.
    2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
    3. A description of the population groups impacted by the demonstration.
    4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
    5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:
    1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
    2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
    3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
    4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published

research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post–only data, with or without comparison groups, etc.

2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected.

4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t–tests, chi–square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration

results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:
    1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    2. If the state did not fully achieve its intended goals, why not?
    3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid or CHIP context and long–range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid or CHIP program, interactions with other Medicaid or CHIP demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid or CHIP. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid or CHIP policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:
    1. What lessons were learned as a result of the demonstration?
    2. What would you recommend to other states which may be interested in implementing a similar approach?

ATTACHMENT C
Evaluation Design [Reserved]

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 15

Audio Transcription: AHCA presentation to Senate Committee on Health Policy

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*** AUDIO TRANSCRIPTION ***

0/7/2025 Senate Committee on Health Policy

for 433987-ATS-1037529 TO Health Policy

* * *

Transcribed

By: Stephanie May

Job No.: 433987

MR. MEYER: All right. Thank you, Chair Burton. So, update on House Bill 121, which expanded CHIP eligibility. So this, this slide is, is really not geared so much to provide, you know -- this deck is -- to, to provide an overview of what the -- what, what the actual legislation did, but to really provide an update on, on where we are. High level, though.

You know, the KidCare program, you know, title 21 is a CHIP program, title 19 for Medicaid is for children. Those two programs combine what we call in Florida the Florida KidCare program. You know, House Bill 121 that was passed in 2023 really recognized that there is a gap between -- on, on the CHIP side in the -- in the premiums that parents have to pay, you know, either $15 or $20 per month in premiums for the CHIP program for, for poverty level up to 200 percent, you know.

But then it stops, you know. And then the, the subsidies stop. And then there's a huge gap up until maybe the marketplace. You know, they also could pay -- you know, do full pay but there's a big gap between the 200

percent FPL of CHIP and potentially 400 percent of income or more for -- from marketplace subsidies.

So what 121 did was really increase the, the, the, the 300 percent of income for federal, federal poverty level and really directed the, the, the Healthy Kids Corporation, you know, which administers a CHIP program -- again, just not a kind of background on the slide here -- to really kind of create new tiers, you know, to help really bridge that gap, to help individuals really kind of transition from perhaps Medicaid to CHIP all the way up to, to Marketplace, all the way up into employer, employer-sponsored health insurance.

And central to the whole CHIP program since its inception in the late 90s was this concept of payment of premiums. It's always been there and it really has been essential to a core component of the program and in the disenrollment of the program for failure to pay premiums.

Again, it's not Medicaid which doesn't have premiums. It's been envisioned as a step

up and a step on the ladder up towards perhaps employer-sponsored insurance, private insurance, whatever, whatever the other alternatives may be. So again, the slide here kind of shows where the -- where we are currently. You know, it's up to the 200 percent of the federal poverty level.

Again, families pay a premium of $15 between 133, 150 or 20 between -- $20 between 150 percent and 200 percent. Now if a family's income drops or decreases, they just drop into the lower tier. And again, over on the right, you know, after 121 is implemented, it will -- which is not implemented, you know, it'll increase to, to 300 percent.

And there's, there's six different tiers in, in there to kind of help with graduating levels of income there. Again, similar component though, if somebody -- if a family member's income decreased, they would just be dropped into a lower tier.

All right. So this is really where, where we are on this. There -- this has been a bit of a long road to, to get -- to get to kind of where we are. And, and there hasn't

been much movement on it this, this past year.

After this was passed, you know, the -- this -- we were working with the Biden administration to kind of -- on how to implement this. The initial approach would have been a state plan amendment just to increase the income limits. They said that was no longer an option and presented us really with, like, an 1115 waiver as one of the options.

So we went ahead with the 1115 waiver and, and submitted the, the waiver to, to implement the program. Normal process, you know, followed normal process. Everything was fine up until, like, November 15th, 2024. And there's some things that happened in between there related to continuous eligibility, rule interpretations, and whatnot. So I'll get to that.

But essentially, November 15th, we received draft special terms and conditions from CMS related to, to -- which is the normal part of the process and generally starts the negotiation process. You always negotiate the STCs with an 1115. We got them, we got a call

from them letting us know this is going to be coming.

But, you know, as the next slide will, will show, we had some pending litigation with CMS related to a rule interpretation, how they are interpreting the continuous eligibility requirements for Medicaid and CHIP that passed under the 2023 Consolidated Appropriations Act.

So because of that litigation, we got a call from them letting us know we were going to be getting these STCs but they had added in our inability to disenroll for, for nonpayment of premiums, which has been, you know, what our litigation was about based on CMS's interpretation. So essentially, you know, we sent back our revisions that -- you know, striking that out, you know, the normal negotiation process.

On December 2nd, we got an approval from them. Again, very out of the ordinary process. This is that -- the, the tail end of the Biden administration, very unordinary process in terms of how you would negotiate the special terms and conditions. We

basically just got an approval with, with the -- with the -- that STC that which we didn't agree with.

All right. And then, you know, we got on December 2nd with -- I think with 30 days to accept them, as, as typically goes. We asked for an extension until 2/1 for the -- for the new Trump -- for the Trump administration to, to evaluate and, and review it, they refused. They gave us an extension until the January 14th, you know, the last two days I think of the -- of the administration, Biden administration.

So the, the, the timeline expired on the waiver approval, you know, based upon how they, they chose to proceed in that respect. So if I go to this next slide here, I'll also -- kind of small, I apologize.

So what this really all comes down to is on October 27th, 2023, like, about probably 10 months or so after the, the, the 2023 Consolidated Appropriations Act, which, which imposed a new 12-month continuous eligibility requirement for Medicaid and CHIP, CMS issued some FAQs which provide -- which I guess were

intended to provide some guidance as subregulatory guidance -- it's not official rule -- in which they first introduced this concept or this interpretation that you can no longer disenroll children from a CHIP program for, for nonpayment of premium. All right.

So on February 1st, the agency filed a complaint in federal district court or court related to that. And then this is -- kind of speaks to the timeline of, of where -- of how we got there in, in various legal motions, you know.

On July 22nd, after the FAQs, they did publish a, a notice of proposed rule that kind of sought to codify that requirement about failure -- not, not being able to disenroll members for failure to pay premiums on the CHIP program. And in November 27th, the final rule was published effective for January 1st, 2025.

So on January 2nd, because we had not implemented that, because we had challenged the rule, then I think on December 13th, both parties moved to dismiss the appeal, various legal reasons. On January 1st, that rule

became effective.

On January 2nd, we got a notice of Florida being placed on a corrective action plan or not being placed on one, but to submit a corrective action plan as to how we were going to come into compliance with the, the, the new rule that prevented disenrollments for failure to pay premiums.

So on January 7th, we filed a new complaint challenging that rule, you know, because now we were being asked to come up with a corrective action plan on that. And that's really -- that was earlier this year. And that's kind of where -- we're still in litigation on this point. You know, as you can see here, the government -- Department of Justice under the Trump administration has filed a couple of stays and requested a couple of stays.

And most recently, both parties have agreed to continue the stay. And we are in negotiations, I think, with the Department of Justice on alternative approaches that we can -- we can implement this. You know, the, the litigation challenge is the rule but we're,

we're looking to see if there are other opportunities in which we could proceed and implement the House Bill 121, as it was -- as it was designed. So I think that is -- that's where we ended up.

CHAIR BURTON: Thank you.

MR. MEYER: That's where we are now.

CHAIR BURTON: Appreciate that. Thank you. That was a lot of information. Do we have any questions? I'll look -- I'll look over this. Any questions? Senator Osgood, you're recognized.

MS. OSGOOD: Thank you. And Madam Chair, please indulge me for a moment. I'm not an attorney. And it seems like we made a good faith effort with HB 121 because we wanted to make sure that there was not a gap. And if I'm understanding you correctly, we continue to have challenges with the federal government. I don't care which administration it is. I'm just trying to get to the bottom line.

So is that why we have not implemented the 300 percent threshold? Because in Broward County, I haven't seen it advertised and I've

been told that they have -- they're not allowed to at this point.

CHAIR BURTON: Sorry. You're recognized

MR. MEYER: Yeah.

CHAIR BURTON: We're looking at the clock and trying to figure out how we --

MR. MEYER: Certainly. Yes. That's, that's precisely why it hasn't been implemented. You know, the legislation, you know -- we were -- we developed the six different premium tiers for payment of premium and not able to implement the legislation as, as passed.

And, you know, regardless of the administration, we're hopeful that we can get to a place, you know, with the current administration that, that will enable implementation of the program.

MS. OSGOOD: Madam Chair.

CHAIR BURTON: You're recognized.

MS. OSGOOD: Thank you. As I'm thinking about the extreme rates of anxiety, we've been seeing a lot of unfortunate deaths. How are we as a state integrating behavior health services into KidCare?

CHAIR BURTON: You're recognized.

MR. MEYER: Just behavioral health service and KidCare in general. I, I don't -- the KidCare program is, is, is largely operated by the Florida Healthy Kids Corporation. So I, I think certainly they would be the best to speak to the, the suite of services covered under the -- under the CHIP program. However, we're, we're certainly happy to, to follow up and provide additional information on that.

MS. OSGOOD: Okay. One final question.

CHAIR BURTON: You're recognized.

MS. OSGOOD: Thank you, Madam Chair. How does the Florida 12th month continues eligibility policy align with the federal CHIP requirements under the big beautiful bill.

CHAIR BURTON: You're recognized.

MR. MEYER: Well, I think that the, the big beautiful bill didn't implement requirements that said you had to, to -- you couldn't go past the 12 months to, to determine eligibility but it enabled you to do it.

You know, I think, you know -- so I

think, you know, in terms of the, the KidCare program here in, in 121, the issue isn't so much around determining whether someone's eligible or not more frequently or -- you know, the, the agency's position -- the state's position is that, you know, there's only one eligibility determination with respect to this and that disenrollment for failure to pay premiums is, is separate from an eligibility determination.

So that's related to this. And, and the implementation delay is really around the concept of disenrollment for disenrolling a member for failing to pay a premium.

MS. OSGOOD: Thank you.

CHAIR BURTON: Thank you. Senator -- excuse me. Senator Harrell, you're recognized.

MS. HARRELL: Thank you very much. And this is very distressing. We passed Hospita l121 back in 2023. I remember, Senator calatayud was a sponsor here in the house and we were all 100 percent behind that bill. So we are being -- if, if you would clarify for me.

So I totally understand we are essentially being held hostage on implementation of raising the eligibility level to 300 percent under the waiver because of this lawsuit? And when do you think there might be a resolution of this so that we can move forward with raising the eligibility to 300 percent of poverty?

CHAIR BURTON: You're recognized.

MR. MEYER: Yeah. So, so, we, we are certainly proponents of the -- of, of the legislation. We, we would -- we would have implemented it long ago if, if we could. As noted on here, just last month was the most recent filing. And we are continuing to have conversations related to, to kind of settling this. That -- that'll be in a minimal position to this state, so -- and also maybe to the federal government.

So we're hopeful that we are -- we'll get somewhere hopefully in the near future on this. I can't, unfortunately, you know, extract -- it's, it's gone on for a bit so it's difficult to, to predict the timeline.

We are certainly committed to finding

alternative pathways forward to implement the legislation, working with the Department of Justice if there are ways that we can do this, whether it's through STCs that we got on there or whatnot, that -- so that Florida can move forward with this program as, as the legislation intended.

So, you know, we've had conversations with CMS as well at the higher levels of CMS and they're also aware of this -- of this issue in our litigation on this matter in that we have not been able to, to increase the, the income limits to bring in additional children into the program because of -- because of this.

CHAIR BURTON: You're recognized.

MS. HARRELL: Just one, one quick follow up. Is there anything specifically that we as legislators, as the state, can do legislatively to empower you or to make more specific the requirements that we have in place for eligibility, not for payment of premiums? And why the two are connected in this situation is beyond me.

But is there anything we can do to assist

you in making sure that this waiver is implemented, that we are -- that children under 300 percent of poverty have access to KidCare?

CHAIR BURTON: You're recognized.

MR. MEYER: So, again, I think we're hopeful that we can get somewhere amenable with, with the federal government here in the near future. However, we're -- we are more than happy to continue and, and work with your office or, or any, any legislator's office outside, outside of this, this, this hearing as we move into the next session, if there's opportunity there.

So we're always -- we are certainly happy to, to finding alternative pathways to, to implement this legislation in the event that we, we can't get it passed in its current form.

CHAIR BURTON: Thank you. We probably have additional -- we might have additional questions. Just to let everybody know, our committee was due to end at 10:30. We've -- we have requested an extension to 11 o'clock. We still have a presentation from the

Department of Health that we've -- if we can get to today would be great.

So I know that both Ms. Smoke and Mr. Meyer are available all the time to meet with us individually in case we have additional questions. But just kind of out of -- you know, A, we hope we get the extension, but B, we -- I would like us to get to DOH if we could today. But please, if there's another question -- because -- and we also have a couple people who'd like to speak on their presentation.

So does anybody have any questions that we need answers to right now? Senator Berman, you're recognized.

MS. BERMAN: Thank you, Madam Chair. I'm kind of distraught hearing all this. And I just wondered, do we know how many children have been disenrolled and how many children aren't able to get access to KidCare because of the problems that are going on?

CHAIR BURTON: You're recognized.

MR. MEYER: Are you asking how many have been disenrolled for, for failure to pay premium under the current program or maybe how

many are not accessing the program because the income limit hasn't been raised?

MS. BERMAN: How about both?

CHAIR BURTON: Yes.

MS. BERMAN: Both. Thank you.

CHAIR BURTON: I knew that's what you were going to say.

MS. BERMAN: Yeah.

CHAIR BURTON: You're recognized. Both. She said both.

MR. MEYER: Okay.

CHAIR BURTON: If you know.

MR. MEYER: I, I don't have that information handy but I'm certainly happy to, to work with our Florida Healthy Kid Corporation partners on that information.

CHAIR BURTON: Knowing this committee will probably have some questions after the committee meeting too. And again, I know you're both very receptive to having meetings with all of us to -- so we can continue this discussion. Anybody have a quick question before we --

MS. CALATAYUD: (indiscernible)

CHAIR BURTON: Excuse me?

MS. CALATAYUD: I'll be super brief.

CHAIR BURTON: Super brief. Senator Calatayud, you're recognized.

MS. CALATAYUD: Less of a question, more of a thank you to my colleagues for the great questions. I think you have commitments from the folks on this dais and a lot of senators to work with you to the resolution this year or before the next fiscal year on getting these kids access. And I'll look forward to those conversations and the work. Thank you.

MR. MEYER: Thank you.

CHAIR BURTON: Thank you. Do we have any additional questions? All right. I want to thank you both very much for being here. We do have a few people who would like to speak to us regarding the presentation we just heard.

(End of audio recording.)

CERTIFICATE OF TRANSCRIPTIONIST

I, STEPHANIE MAY, do hereby certify:

That said audio transcription is a true record as reported by me, a disinterested person.

I further certify that I am not interested in the outcome of said action, nor connected with, nor related to any of the parties in said action, nor to their respective counsel.

IN WITNESS THEREOF, I have hereunto set my hand this 29th day of December, 2025.

Stephanie May

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 16

Letter from Chiquita Brooks-Lasure, Adm'r CMS, to Brian Meyer, Deputy Sec'y for Medicaid, AHCA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 2, 2025

Bryan Meyer
Deputy Secretary for Medicaid
2727 Mahan Drive, MS #20
Tallahassee, FL 32308-5403

Dear Deputy Secretary Meyer:

As you are aware, section 2107(e)(1)(K) of the Social Security Act (the Act), as amended by the Consolidated Appropriations Act, 2023 (CAA, 2023), requires states to provide one year of continuous eligibility to targeted low-income children enrolled under the state plan in a separate Children's Health Insurance Program (CHIP), effective January 1, 2024. Florida has not yet submitted a CHIP state plan amendment (SPA) to demonstrate compliance with section 2107(e)(1)(K) of the Act to the Centers for Medicare & Medicaid Services (CMS) for review.

The CAA, 2023 made fundamental changes relevant to continuous eligibility for children, including requiring that the 12-month continuous eligibility period must apply to coverage under a separate CHIP "in the same manner" as it does to Medicaid coverage. In response to the CAA, 2023, CMS removed the previous regulatory exception in 42 C.F.R. 457.342(b), which provided States the option to disenroll children from a separate CHIP during a continuous eligibility period for nonpayment of premiums, as that exception is not consistent with the statutory requirement (since the CHIP disenrollment policy does not currently, and did not previously, apply to Medicaid prior to the CAA, 2023 amendments). These changes were finalized in the "Medicare and Medicaid Programs: …Medicaid and CHIP Continuous Eligibility" final rule (89 FR 93912) that appeared in the Federal Register on November 27, 2024, and were effective January 1, 2025.

According to Florida's CHIP state plan, Florida currently disenrolls children during a continuous eligibility period from its separate CHIP due to nonpayment of premiums. This policy is no longer allowable under 2107(e)(1)(K) of the Act and 42 C.F.R. 457.342. Florida must submit a CHIP SPA demonstrating that the State has removed this exception to continuous eligibility in its separate CHIP.

Florida must complete a Corrective Action Plan (CAP) to address these issues. CMS requests that the CAP contains the following elements:

1) A CHIP SPA articulating an approvable continuous eligibility policy;
2) Reenrollment of all children, through the end of their initial continuous eligibility period, who have been disenrolled due to failure to pay premiums during the continuous eligibility period between January 1, 2025 and the implementation date of the CHIP SPA effectuating the continuous eligibility policy in a manner compliant with federal requirements; and

3) A timeline for completion of the CAP.

Please respond within 30 days from the date of this letter with a CAP that describes the actions the State is taking to fully comply with the statutory and regulatory requirements listed above. If Florida believes that its existing CHIP state plan is already in compliance with the new statutory and regulatory continuous eligibility requirements, the state may instead submit within 30 days an explanation for CMS review.

States that are not in compliance with federal regulations are subject to further compliance action, including potential withholding of federal funds, in accordance with the procedures outlined in 42 C.F.R. 457.204 and 457.206. This letter serves as the required preliminary notice and opportunity for correction under 42 CFR 457.204(d)(1) and (2). CMS will take into account any information submitted by Florida within the next 30 days and, if appropriate, issue a final notice of the findings of noncompliance. An opportunity for a hearing will be provided to the State prior to withholding federal funds.

CMS is available to provide any technical assistance that you need during the next 30 days as you prepare your response. If you have questions or concerns regarding the matters raised in this letter, please contact Sarah deLone, Director, Children and Adults Health Programs Group, at (443) 934-2734.

Sincerely,

Chiquita Brooks-LaSure

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 17

Declaration of Joceyln Durant

DECLARATION OF JOCELYN DURRANT

1. My name is Jocelyn Durrant.

2. I am over the age of 18 and have personal knowledge of the facts stated in this declaration.

3. I live in Indian River County, Florida, with my husband and our two sons, D.D., approximately four (4) years old, and J.D., who turned one (1) year old in late January 2026.

4. Our household's gross income, which consists solely of my husband's salary, is approximately $6,942 per month.

5. D.D. was diagnosed with Level 3 Autism and a brain condition when he was an infant. He is developmentally delayed and is non-verbal. My husband and I communicate with him using the Picture Exchange Communication System (PECS). For example, we use magnets with pictures of his favorite foods to enable him to choose what he wants to eat, and pictures of daily activities to help him transition to different activities during the day. D.D. enjoys engaging in self-stimulating activities with legos and puzzles, and he shows a strong interest in and aptitude for mechanical activities.

6. D.D. requires an intensive therapy schedule, including ABA therapy, occupational therapy, and speech therapy.

7. I do not work outside the home, in part, because I need to attend to D.D.'s special medical needs and also care for his younger brother.

8. D.D. was initially enrolled in a federal Health Insurance Marketplace plan.

9. After he turned one (1) year old, we were able to enroll D.D. in the CHIP KidCare program.

10. D.D. was subsequently determined by the Social Security Administration to be disabled, and our family received supplemental security income (SSI) payments for a brief period. Due to his eligibility for SSI, D.D. was enrolled in Medicaid.

11. I was unaware that D.D.'s disability determination would cause us to receive SSI payments, or that it would trigger a change in D.D.'s coverage to Medicaid.

12. We stopped receiving SSI payments shortly after they started because our income made D.D. ineligible.

13. Due to the loss of SSI, D.D. was disenrolled from Medicaid on October 31, 2025.

14. D.D. was uninsured during the month of November 2025. We had to drastically reduce hours of ABA therapy and make other financial sacrifices to pay out-of-pocket for his ABA therapy.

15. In early November 2025, I applied to KidCare for coverage for D.D.

16. I received a notice dated November 12, 2025, stating that the premium for D.D.'s insurance would be $248.21 per month because "you do not qualify for lower cost health coverage."

17. I understood from the KidCare website that because our household income was over the income limit to qualify for the CHIP KidCare program, D.D. could not enroll in the Children's Medical Services Program. I confirmed this understanding when I spoke with a KidCare representative.

18. D.D. remains enrolled in Full-Pay KidCare today, for which we pay $248.21 per month.

19. D.D.'s younger brother, J.D., was initially insured through the Federally Facilitated Marketplace, but we had to disenroll him because we could no longer afford that insurance after the federal government stopped offering premium assistance.

20. J.D. did not qualify for Full-Pay KidCare until after he turned one (1) year old in January.

21. As soon as J.D. turned one (1) year old, we applied to enroll him in KidCare.

22. On February 5, 2026, FHKC sent a notice almost identical to that for D.D., which said that J.D. "did not qualify for lower cost health coverage" because we make too much money.

23. FHKC said that if we paid an additional $248.21 per month, on top of the $248.21 premium we pay for D.D. (for a total premium payment of $496.42 per month), then we could enroll J.D. in Full-Pay KidCare.

24. We paid that premium on February 5, 2025, and J.D. is currently enrolled in Full Pay KidCare like D.D.

25. It is my understanding that, because our household income is below 300% FPL, J.D. should also qualify for CHIP KidCare, but because FHKC is using the 200% FPL limit, J.D. is eligible only for Full-Pay KidCare.

26. It is also my understanding that under CHIP KidCare, we would pay a single premium for both D.D. and J.D. rather than a separate premium for each of them. This would save us a significant amount of money per month, which we could put toward expenses. Specifically, D.D. needs to see certain medical specialists that are not covered by his current KidCare plan, including a neuropsychologist for his specific brain condition. We will have to pay

out of pocket for some specialists that are outside his plan, so having a lower premium would be a tremendous help in paying for the care and treatments D.D. needs.

Pursuant to Section 92.525, Florida Statutes, under penalties of perjury, I declare that I have read the foregoing declaration and that the facts stated in it are true.

Signed: **Dated:**

03/06/2026

Jocelyn Durrant

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA

CIVIL DIVISION

CASE NO.

D.D. & J.D., by and through their Next Friend, Jocelyn Durrant; D.M., by and through his Next Friend, Rebbeca Morris,

Plaintiffs,

v.

Florida Healthy Kids Corporation and Florida Agency for Health Care Administration,

Defendants.
_____/

EXHIBIT 18

Declaration of Rebbeca Morris

DECLARATION OF REBBECA MORRIS

1. My name is Rebbeca Morris.

2. I am over the age of 18 and have personal knowledge of the facts stated in this declaration.

3. I live in Broward County, Florida, with my son, D.M., who is eight (8) years old.

4. Our household's gross income, which consists solely of my salary, is approximately $4,492 per month.

5. D.M. has been diagnosed with Autism, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, and Attention-Deficit/Hyperactivity Disorder. He has been determined to be disabled by the Social Security Administration. He is currently in second grade in an Emotional/Behavioral Disability cluster class. He loves swimming and being outside, and has recently expressed an interest in participating in sports.

6. D.M. was enrolled in Medicaid starting at birth. Because it was clear shortly after he was born that he was not meeting developmental milestones, D.M. was enrolled in the Children's Medical Services Program. The program provided specialized services for D.M.'s chronic and serious medical conditions.

7. The Children's Medical Services Program was especially helpful in covering Applied Behavior Analysis (ABA) therapy, which enabled D.M. to make significant progress in regulating his behavior. At some point D.M. was disenrolled from Medicaid because my income was too high.

8. I enrolled D.M. in the health insurance program available through my employer. However, my employer-sponsored health insurance program became unaffordable due to significant increases in monthly premiums and co-payments.

9. In August, 2025, I enrolled D.M. in Florida KidCare.

10. I received a notice dated August 5, 2025, stating that the premium would be $276.00 per month, or $256.00 without dental, because "you do not qualify for lower cost health coverage."

11. Additionally, a KidCare representative informed me that because our household income was over the income limit to qualify for the CHIP KidCare program, D.M. could not enroll in the Children's Medical Services Program.

12. It is my understanding that if D.M. qualified for CHIP KidCare, the premium would be substantially lower. This would help me tremendously in being able to afford groceries and clothes for D.M. It would also help me pay for tutoring for D.M., which he needs because he is not meeting grade level benchmarks in school.

13. It is also my understanding that if D.M. qualified for CHIP KidCare, he would be able to enroll in the Children's Medical Services Program, which would provide specialized services for D.M.'s chronic and serious medical conditions.

14. D.D. remains enrolled in Full Pay KidCare today, for which I pay $276.00 per month. D.M. is not enrolled in the Children's Medical Services Program.

Pursuant to Section 92.525, Florida Statutes, under penalties of perjury, I declare that I have read the foregoing declaration and that the facts stated in it are true.

Signed: **Dated:**

Rebbeca Morris (Mar 6, 2026 17:57:11 EST)

Rebbeca Morris

Mar 6, 2026