Florida CARTS FY2020 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Florida

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

Florida KidCare CHIP - Healthy Kids Program, MediKids, and Children Medical Services Health Plan

Who should we contact if we have any questions about your report?

4. Contact name:

Ann Dalton

5. Job title:

Acting Chief of Medicaid Policy

6. Email:

Ann.Dalton@AHCA.myflorida.com

7. Full mailing address:

Include city, state, and zip code.

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(850) 412-4000

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ◉ No

3b. What's the maximum premium a family would be charged each year?

$

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

No

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☐ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

CHIP funded Medicaid Expansion enrollees are given the opportunity to make a health plan choice when they apply for eligibility. Health plan enrollment is effective the same day the individual's Medicaid is approved. If the family wishes to select another health plan, they have 120 days to select a different plan.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- (●) Yes

  2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

  - ( ) Yes
  - (●) No

  2c. How much is the premium for one child?

  $

- ( ) No

3. Is the maximum premium a family would be charged each year tiered by FPL?

◉ Yes

3a. Indicate the range of premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at	FPL ends at
133	158

Premium starts at	Premium ends at
$ 15	$ 15

FPL starts at	FPL ends at
159	210

Premium starts at	Premium ends at
$ 15	$ 15

○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

Ages 1 through 5, between 140% and 158% FPL, Florida KidCare Separate CHIP Family Premium of $15 Ages 6 through 18, between 133% and 158% FPL, Florida KidCare Separate CHIP Family Premium of $15 Ages 1 through 5, between 140% and 158% FPL, Florida KidCare Separate CHIP Family Premium of $15 Ages 6 through 18, between 133% and 158% FPL, Florida KidCare Separate CHIP Family Premium of $15 Ages 1 through 5, between 158% and 210% FPL, Florida KidCare Separate CHIP Family Premium of $20 Ages 6 through 18, between 158% and 210% FPL, Florida KidCare Separate CHIP Family Premium of $20

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [ ] Primary Care Case Management
- [ ] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All KidCare enrollees (Medicaid Expansion and CHIP) are required to be enrolled in a health care plan before medical and dental services are provided.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing

the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- (●) Yes
- ( ) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ( ) Yes
- (●) No
- ( ) N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ( ) Yes
- (●) No
- ( ) N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to your Pregnant Women State Plan expansion?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- ◉ Yes
- ○ No
- ○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7:

"Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	172,459	143,397	-16.852%
Separate CHIP	299,427	318,329	6.313%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

Beginning in FY 2020-21, the annual caseload projections for the entire KidCare Program were lower than estimated at the beginning of SFY 2020. The decrease in the forecast results from lower projected enrollments for each of the individual CHIP programs (subsidized and full-pay) and are largely a result of the persistent pandemic-induced economic contraction. The program effects are varied but include a shift of a portion of the previously expected CHIP caseload into Medicaid as the number of unemployed remains high. In responses to the COVID-19 PHE, policy changes at the federal, State, and programmatic level, including the retention of Medicaid enrollees, have also impacted enrollment for both the CHIP and Medicaid programs.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	195,000	11,000	4.6%	0.2%
2016	166,000	12,000	3.9%	0.3%
2017	179,000	12,000	4.1%	0.3%
2018	174,000	11,000	3.9%	0.3%
2019	176,000	13,000	4%	0.3%

Percent change between 2018 and 2019
NaN%

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

(●) Yes

1a. What are you doing differently?

New marketing and advertising platforms have been utilized, such as Connected TV and over-the-top (OTT) video advertising to offset the decrease of in-person outreach due to the COVID-19 PHE. The program implemented new training through electronic means, such as Zoom and Teams, to provide existing community outreach partners with alternative outreach tools to reach families that may need health insurance, or to change their existing health insurance, due to household income changes caused by COVID-19. These include telephonic outreach to applicants who have not formally submitted a signed application and outreach via paid social media advertising to targeted socioeconomic audiences.

( ) No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

- (●) Yes

  2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

  Yes, the KidCare Program is working with a marketing partner to launch an advertising and outreach campaign specifically designed to target non-English speaking families. By extending its reach to new audiences, such as institutions of faith, cultural centers and Hispanic chambers of commerce, the campaign aims to convey the importance of health coverage in culturally relevant ways. This campaign will measure knowledge about the program from the start to end of the campaign among targeted audiences, as well as the number of increased enrollments among targeted audiences. Complications due to COVID-19 have paused the outreach to this targeted population. This campaign is expected to relaunch in early 2021.

- ( ) No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

To reach families with uninsured children, the KidCare program has increased its digital advertising spend on Google, Facebook, Pinterest, and other social media platforms. These efforts are tracked through traditional advertising metrics, such as views, overall cost per thousand impressions (CPM), and total number of completed applications and new enrollments. Paid search has proven the most effective and cost-effective digital tactic. Additionally, new year-round community outreach partners have been added in densely populated areas in January 2020 to increase the number of person-to-person outreach opportunities across the state. These partners later created an expanded network of telephonic outreach once COVID-19 reached a level preventing in-person public outreach from taking place. Despite the difficulties the COVID-19 pandemic provided, partners were also able to reach families through drive-thru or virtual partnerships. Outreach partner efforts are measured by individual reach, extent of education and information provided to qualified leads, as well as direct application assistance. This information can be viewed internally and measured against other partnerships to determine effectiveness.

4. Is there anything else you'd like to add about your outreach efforts?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with

private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

4.48 %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

◉ Yes

4a. How long is the waiting period?

60 days

4b. Which populations does the waiting period apply to? (Include the FPL for each group.)

To be eligible for Title XXI Florida KidCare, the family income must not exceed 210% of the federal poverty level and the child must be uninsured at the time of enrollment. To prevent crowd-out, applicants who voluntarily cancel their employer-based coverage or private health care coverage in the 60 days prior to application are not eligible for subsidized coverage. Children not eligible due to crowd-out policies may participate in the non-subsidized Healthy Kids and MediKids program during the 60-day waiting period. Families pay the full cost of the health care coverage which, for the report year, was $230 per child per month with dental, and $215 per child per month without dental for Healthy Kids (ages 5 through 18). For MediKids (ages 1 through 4), prior to October 1, 2020 the per child per month premium was $157 for health and dental. Starting October 1, 2020, the MediKids full-pay premium is $187.96 per child per month.

4c. What exemptions apply to the waiting period?

The following exemptions apply to the 60-day waiting period: • The cost of participation in an employer-sponsored health benefit plan is greater than 5% of the family's income; • Parent lost a job that provided an employer-sponsored health benefit plan for the child; • Parent who had health benefit coverage for the child is deceased; • The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death; • The employer of the parent canceled health benefits coverage for children; • The child's health benefits coverage ended because the child reached the maximum lifetime coverage amount; • The child has exhausted coverage under a COBRA continuation provision; • The health benefits coverage does not cover the child's health care needs; or • Domestic violence led to the loss of coverage.

4d. What percent of individuals subject to the waiting period meet a state or federal exemption?

This data is not tracked in the aggregate.

- ○ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting data?

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?
This question should only be answered in respect to Separate CHIP.

- ○ Yes
- ◉ No
- ○ N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ◉ Yes
- ○ No

3. Do you send renewal reminder notices to families?

◉ Yes

3a. How many notices do you send to families before disenrolling a child from the program?

Two notices are sent. The administrative renewal process is attempted for all families, but if income data is not available, the family is sent a pre-populated renewal form, followed by an auto dial call. If renewal information is incomplete, a missing information letter is mailed, followed by an auto dial call. A reminder letter is mailed one month later, followed by an auto dial call. Upon completion, a renewal complete letter is sent. If the renewal is not completed, a cancellation letter is sent the 20th day of the month before coverage is cancelled.

3b. How many days before the end of the eligibility period did you send reminder notices to families?

See explanation above.

○ No

4. What else have you done to simplify the eligibility renewal process for families?

The KidCare programs provide the contracted managed care plans and dental plans the renewal date for each enrollee on their enrollment files. The plans use this information for special mailings and automated telephone calls for their retention efforts.

5. Which retention strategies have you found to be most effective?

The expedited renewal process has proven successful because it requires little direct interaction from enrollees. Additionally, outbound calls prove effective in that they create a far more immediate response from enrollees when compared to letters sent through postal mail.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

Enrollment and renewal data are tracked through interactive data visualization tools, such as Tableau, which provide real-time trend data. Also, enrollment retention is tracked using SQL queries that allow for studying the effects of different retention strategies.

7. Is there anything else you'd like to add that wasn't already covered?

No.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2020?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

271696

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

64592

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

204396

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

28580

4. How many applicants were denied CHIP coverage for other reasons?

2708

5. Did you have any limitations in collecting this data?

No.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	23.77%
Denied for eligibility reasons	75.23%
Denials for other reasons	1%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2020?

209139

2. Of the eligible children, how many were then screened for redetermination?

209139

3. How many children were retained in CHIP after redetermination?

197681

4. How many children were disenrolled in CHIP after the redetermination process? This number should be equal to the total of 4a, 4b, and 4c below.

11449

4a. How many children were disenrolled for procedural reasons? This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

66

4b. How many children were disenrolled for eligibility reasons? This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

8766

4c. How many children were disenrolled for other reasons?

2617

5. Did you have any limitations in collecting this data?

No.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	94.52%
Children disenrolled after redetermination	5.47%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	0.58%
Children disenrolled for eligibility reasons	76.57%
Children disenrolled for other reasons	22.86%

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year

changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2020?

1623131

2. Of the eligible children, how many were then screened for redetermination?

1217837

3. How many children were retained in Medicaid after redetermination?

1171447

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

46390

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

37936

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

6981

4c. How many children were disenrolled for other reasons?

1473

5. Did you have any limitations in collecting this data?

No.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	96.19%
Children disenrolled after redetermination	3.81%

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	81.78%
Children disenrolled for eligibility reasons	15.05%
Children disenrolled for other reasons	3.18%

Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or

younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

◉ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

○ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	11028	19817	7813

July - September 2020 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	7083	12003	4863

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	650	1342	587

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	12	<11

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	3295	6472	2363

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	1866	3536	1197

9. Is there anything else you'd like to add about your data?

No.

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

◉ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

○ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
19971	8252	7100	2952

July - September 2020 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
19375	7752	6524	2695

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
154	84	57	42

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
516	466	575	237

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	5087	8059	3086

9. Is there anything else you'd like to add about your data?

No.

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in Medicaid 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- (●) Yes
- ( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- (●) Families ("the shoebox method")

  2a. What information or tools do you provide families with so they can track cost sharing?

  The Florida Healthy Kids Corporation contracted third party administrator calculates each family's 5 percent cost-sharing limit and includes this dollar amount in eligibility approval notices sent to families. Florida Healthy Kids is the only Title XXI program component that charges copayments. Cost sharing for Florida Healthy Kids children is tracked by enrollees through the shoebox method. The health plans track the copayments paid by families and provide this information through their member portals or upon request. Since the health plans do not know the family's income, they cannot calculate the 5 percent cost-sharing limit. When the family has met the 5 percent limit, they contact the third-party administrator and provide documentation (e.g., receipts) of their expenditures. The Florida Healthy Kids Corporation reviews the documentation and notifies the health plan when a family has reached the 5 percent cost-sharing limit. At that point, the health plan does not charge copayments for the remainder of the continuous eligibility period. The health plan is required to notify providers that the child should no longer be charged copayments. Dental services provided under the Florida Healthy Kids dental plan have no cost sharing; all services are free to the enrollee.

- ( ) Health plans
- ( ) States
- ( ) Third party administrator

○ Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

Health plans notify providers that no cost sharing should be charged for these enrollees via notification through the provider portal, notification during eligibility and enrollment confirmations with the provider's office, and letters to providers. The health plan confirms this information upon request, such as via telephone. Upon request, the Florida Healthy Kids Corporation will issue a letter to the family that can be used at providers' offices as proof of the cost sharing exemption. The health plan may also issue a new identification card that indicates zero copayments.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

None reported - 0

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

○ Yes

◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

○ Yes

◉ No

8. Is there anything else you'd like to add that wasn't already covered?

No.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- ○ Yes
- ◉ No

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- ○ Yes
- ◉ No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- ○ Yes
- ◉ No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- ○ Yes
- ◉ No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

The Title XXI Florida KidCare programs do not have a separate written plan for fraud and abuse prevention and investigation; however, section 409.814(9) and (10), Florida Statutes, explicitly details the requirements for fraud and abuse prevention and investigation. As the central processor for eligibility for the non-Medicaid components of the Florida KidCare program, the Florida Healthy Kids Corporation has an eligibility review unit. This unit researches eligibility issues and responds to inquiries regarding an individual child's eligibility. Requests for such reviews come from the managed care organizations, external entities or individuals, or anonymous reports.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

◉ Yes

5a. What safeguards and procedures do the Managed Care plans have in place?

The managed care plans have administrative and management arrangements and procedures to detect and prevent Fraud, Waste and Abuse that comply with all state and federal laws and regulations, including 42 CFR 457.1285. The arrangements and procedures include the following: a. A compliance program that includes: i. Written policies, procedures and standards of conduct detailing Insurer's commitment to comply with all applicable requirements and standards; ii. A compliance officer responsible for developing and implementing the policies, procedures and practices designed to ensure compliance with the Contract. The compliance officer shall have sufficient experience in healthcare and shall report directly to the CEO and Insurer's board of directors; iii. A regulatory compliance committee on the board of directors and at the senior management level charged with overseeing Insurer's compliance program and its compliance with the Contract; iv. A system for training and educating the compliance officer, senior management and Insurer's employees about state, federal and contractual requirements; v. Effective lines of communication between the compliance officer and Insurer's employees, as evidenced by some formal policy; vi. Enforcement of standards through well-publicized disciplinary guidelines; vii. Non-retaliation policies against any individual that reports violations of Insurer's Fraud and Abuse policies and procedures or suspected Fraud and Abuse; and viii. A system, and related procedures, with dedicated staff for routine internal monitoring, auditing of compliance risks, prompt response to, investigation of, and correction of compliance issues, actions to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements of the Contract. b. A method used to verify services that were represented to have been delivered by network Providers were received by Enrollees. Such verification process shall be conducted on a regular basis; c. The distribution of written policies to Insurer's employees, and of any Subcontractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about the rights of employees to be protected as

whistleblowers; d. Prompt reporting to the Florida Healthy Kids Corporation of information Insurer obtains indicating Fraud or potential Fraud by a Provider, Subcontractors, Applicant or Enrollee; e. Suspension of payments to a network Provider when the Florida Healthy Kids Corporation or AHCA determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23; and f. Policies and procedures to maintain adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist Insurer with preventing and detecting potential Fraud and Abuse activities.

- ○ No
- ○ N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2020?

0

7. How many cases have been found in favor of the beneficiary in FFY 2020?

0

8. How many cases related to provider credentialing were investigated in FFY 2020?

0

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

0

10. How many cases related to provider billing were investigated in FFY 2020?

0

11. How many cases were referred to appropriate law enforcement officials in FFY 2020?

0

12. How many cases related to beneficiary eligibility were investigated in FFY 2020?

0

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

0

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- (●) CHIP only
- ( ) Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ( ) Yes
- (●) No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

- (●) Yes

    16a. What specifically are the contractors responsible for in terms of oversight?

    Florida CHIP program managed care plans are required by Florida statute to investigate potential fraud and abuse and refer cases to law enforcement and/or the Medicaid Program Integrity Bureau as appropriate.

- ( ) No

17. Is there anything else you'd like to add that wasn't already covered?

No.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5" group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	11331	42798	66937	94270	68625

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	2803	17233	37575	48822	31983

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	2651	16320	35935	44116	28704

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	256	4019	15224	18305	13158

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2020?

10858

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

No.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction.

1. Did you collect the CAHPS survey?

- (●) Yes
  - 1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?
    - ( ) Yes
    - (●) No
- ( ) No

Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.
This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Summary Report-FLCHIP.docx

2. Which CHIP population did you survey?

- ○ Medicaid Expansion CHIP
- ◉ Separate CHIP
- ○ Both Separate CHIP and Medicaid Expansion CHIP
- ○ Other

3. Which version of the CAHPS survey did you use?

- ○ CAHPS 5.0
- ◉ CAHPS 5.0H
- ○ Other

4. Which supplemental item sets did you include in your survey?
Select all that apply.

- ☐ None
- ☑ Children with Chronic Conditions
- ☐ Other

5. Which administrative protocol did you use to administer the survey?
Select all that apply.

- ☑ NCQA HEDIS CAHPS 5.0H
- ☐ HRQ CAHPS
- ☐ Other

6. Is there anything else you'd like to add about your CAHPS survey results?

No.

Part 3: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

School Health Services Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Students age 4 through 18 years in 66 Florida counties that receive state general revenue and Title XXI revenue to implement Comprehensive School Health Services and Full Service School programs.

4. How many children do you estimate are being served by the HSI program?

771005

5. How many children in the HSI program are below your state's FPL threshold?

133384

Computed: 17.3%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Yearly reported numbers of nursing assessments and individualized healthcare plans for students with chronic and/or complex health conditions and students presenting in school clinics with illness or injury.

7. What outcomes have you found when measuring the impact?

During the past five years, annual reports submitted by all Florida school health programs are showing reductions in registered nursing assessments and individualized healthcare plans due to the following: • Revenue shortfalls in Florida's local school health programs has resulted in discontinuation of hiring new registered school nurses and a move by some local programs to licensed practical nurses and health aide staffing models with limited registered nurses for program management and supervision. • Extended school closures due to hurricanes (hurricanes Michael, Irma, Hermine, and the COVID-19 pandemic (in 2019-2020) when provision of school health services are not provided (except for student welfare checks).

8. Is there anything else you'd like to add about this HSI program?

Florida's local school health programs have one registered nurse per three schools providing clinical nursing services to the general student population. The National Association for School Nurses (2020) has adopted the following statement regarding staffing for safe care in schools, "To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day." The increasing numbers of students with chronic and complex health conditions has made this registered nursing shortage in Florida schools a critical situation. The range of health conditions and daily medication routes and health care procedures and treatments required by these students can be seen in the attached document.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...
HSI COVID Impact_2020 CHIP Report.docx

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

The State seeks to work towards moving below the national average over the next few years, once the COVID-19 public health emergency has concluded. The Georgetown University Center for Children and Families analysis of the U.S. Census Bureau, American Community Survey specifies Florida's uninsured children rate of 7.6 percent remained the same from FY 2018 to 2019.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Florida children under age 19 represented in the ACS survey who lack health insurance.

4. Numerator (total number)

343000

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Florida children under age 19 represented in the ACS survey

6. Denominator (total number)

4480000

Computed: 7.66%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The rate remained the same from last year.

10. What are you doing to continually make progress towards your goal?

The State's improved enrollment processes, aggressive marketing efforts and outreach, as well as relaxed eligibility criteria in light of the COVID-19 pandemic, may help improve this metric.

11. Anything else you'd like to tell us about this goal?

No.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase access satisfaction with care.

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

To increase family satisfaction with care. The State seeks to increase the number of families satisfied with the care provided under their enrolled Florida KidCare program component by two percentage points between FFY 2020 and 2021 reporting.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Number of complete and eligible CAHPS survey respondents who rated their CHIP plan or program component an "8", "9", or a "10" on a 0-10 scale

4. Numerator (total number)

1676

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Number of complete and eligible CAHPS survey respondents who answered this survey question.

6. Denominator (total number)

2058

Computed: 81.44%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

As this is a new goal, there had not an established target for this year's data.

10. What are you doing to continually make progress towards your goal?

Florida CHIP conducts the CAHPS survey each year to gauge family experiences. Plans conduct performance improvement plans assessing enrollee satisfaction. In addition, plans select families for feedback through focus groups or additional surveys to better understand their opinions about the CHIP program.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

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Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Improve the health status of children in Florida

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

In order to adhere to the established Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics (AAP), our goal is to increase the rate by 2% by FFY 2021 reporting.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

The number of children receiving an age-appropriate (per the AAP guidelines) well child visit during the measurement period.

4. Numerator (total number)

27481

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

The number of CHIP members eligible for a well child visit during the measurement period.

6. Denominator (total number)

38907

Computed: 70.63%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The State did not set a goal for this year's reporting. The State initially set a goal to increase general visit to a primary care provider and met that goal with 94% utilization. With the new focus on well visits, the state expects this rate (70.6%) to be lower.

10. What are you doing to continually make progress towards your goal?

The State encourages the use of medical homes. Having a medical home increases the likelihood of establishing a rapport with a primary care provider and complying with recommended well child visits.

11. Anything else you'd like to tell us about this goal?

This measure is a combination of the totals for the HEDIS W15, W34, and AWC measures as a way to tabulate and report provision of a well child check. Note that these measures were three distinctly separate measures, and able to be calculated using hybrid methodology. Due to changes in the HEDIS measure specifications, these will be two measures and calculated through use of only claims and encounter data. This may result in slightly different totals in subsequent reports.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will this data become available?

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, special healthcare needs, or other emerging healthcare needs.) What have you discovered through this research?

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 1,124,155,338	**$** 1,042,111,436	**$** 1,113,202,601

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 35,175,400	**$** 29,315,728	**$** 31,746,070

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2020	FFY 2021	FFY 2022
Managed Care	1124155338	1042111436	1113202601
Fee for Service	0	0	0
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	35175400	29315728	31746070
Total benefit costs	1159330738	1071427164	1144948671

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?
This includes wages, salaries, and other employee costs.

2020	2021	2022
$ 0	**$** 0	**$** 0

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 2,944,800	**$** 2,928,956	**$** 3,037,167

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 26,154,682	**$** 21,492,967	**$** 20,435,452

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

5. How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 1,200,000	**$** 1,200,000	**$** 1,200,000

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 14,638,436	**$** 15,952,039	**$** 15,995,936

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2020	FFY 2021	FFY 2022
Personnel	0	0	0
General administration	2944800	2928956	3037167
Contractors and brokers	26154682	21492967	20435452
Claims processing	0	0	0
Outreach and marketing	1200000	1200000	1200000
Health Services Initiatives (HSI)	14638436	15952039	15995936
Other administrative costs	0	0	0
Total administrative costs	44937918	41573962	40668555
10% administrative cap	120997770.89	112532856.44	120161836.78

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2020	**FFY 2021**	**FFY 2022**
Total program costs	1204268656	1113001126	1185617226
eFMAP	84.53	73.37	72.72
Federal share	1017968294.92	816608926.15	862180846.75
State share	186300361.08	296392199.85	323436379.25

8. What were your state funding sources in FFY 2020?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1. How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
4840868	4340428	4557778

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
Round to the nearest whole number.

2020	2021	2022
$ 232	**$** 240	**$** 244

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost	232	240	244

Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1. How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020	2021	2022
$	**$**	**$**

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost			

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

No.

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

Florida's Governor and Legislature remain supportive of the role CHIP plays in making affordable, quality healthcare services available to uninsured, low-income children and families. From a fiscal perspective, the process includes a review of enrollment, projected enrollment, revenues, and expenses. Specifically, the Florida KidCare Social Services Estimating Conference (SSEC) convenes several times each year. Representatives from the Executive Office of the Governor, the Florida Legislature, and the Division of Economic and Demographic Research evaluate the program's enrollment and expenditures and make recommendations for the state's annual legislative budget. Each year, the Florida Legislature considers the recommendations of the SSEC. Historically, the Florida Legislature has appropriated funds to meet the needs of the program. The 2019 Florida Legislature and the Governor funded a recombination of the CHIP and full-pay (buy-in) populations. Implemented for plan year 2020, this recombination resulted in a CHIP look-alike full-pay benefit plan aimed at reducing the number of uninsured children in Florida.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

The COVID-19 pandemic has impacted all aspects of the CHIP program: children's health, family income, enrollment, and administration. Health plans are providing case management and other support as needed to members and waiving certain copayments and providing COVID-19 educational materials to enrollees. Business disruptions and increased unemployment resulting from the COVID-19 pandemic have lowered family incomes. Consequently, CHIP enrollment has decreased, as applications and members with reduced income have been referred to Florida Medicaid. Throughout the COVID-19 pandemic services to families have continued without disruption. CHIP health plans have monitoring provider networks to ensure children continue to have access to services. The number of providers offering telehealth services has increased.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

The statutory $1 million lifetime benefit maximum limit per child was repealed by the Florida Legislature during the 2020 legislative session.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

To comply with CMS guidance, the $1 million lifetime benefit maximum limit per child was repealed in 2020. To comply with CMS guidance, copays for behavioral health and substance use disorder will be eliminated starting January 2021. Due to the COVID-19 Public Health Emergency the State submitted a Disaster Relief state plan amendment to the CHIP State Plan to include new disaster provisions related to co-payments

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

No.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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