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

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STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: State of Florida
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

Tom Wallace, Deputy Secretary for Medicaid _____ Date

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Tom Wallace	Position/Title: Deputy Secretary for Medicaid
Name:	Position/Title:
Name:	Position/Title:

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 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

Major elements of Florida's Title XXI plan, known as the Florida KidCare Program, include:

Phase 1 (*effective April 1, 1998*)

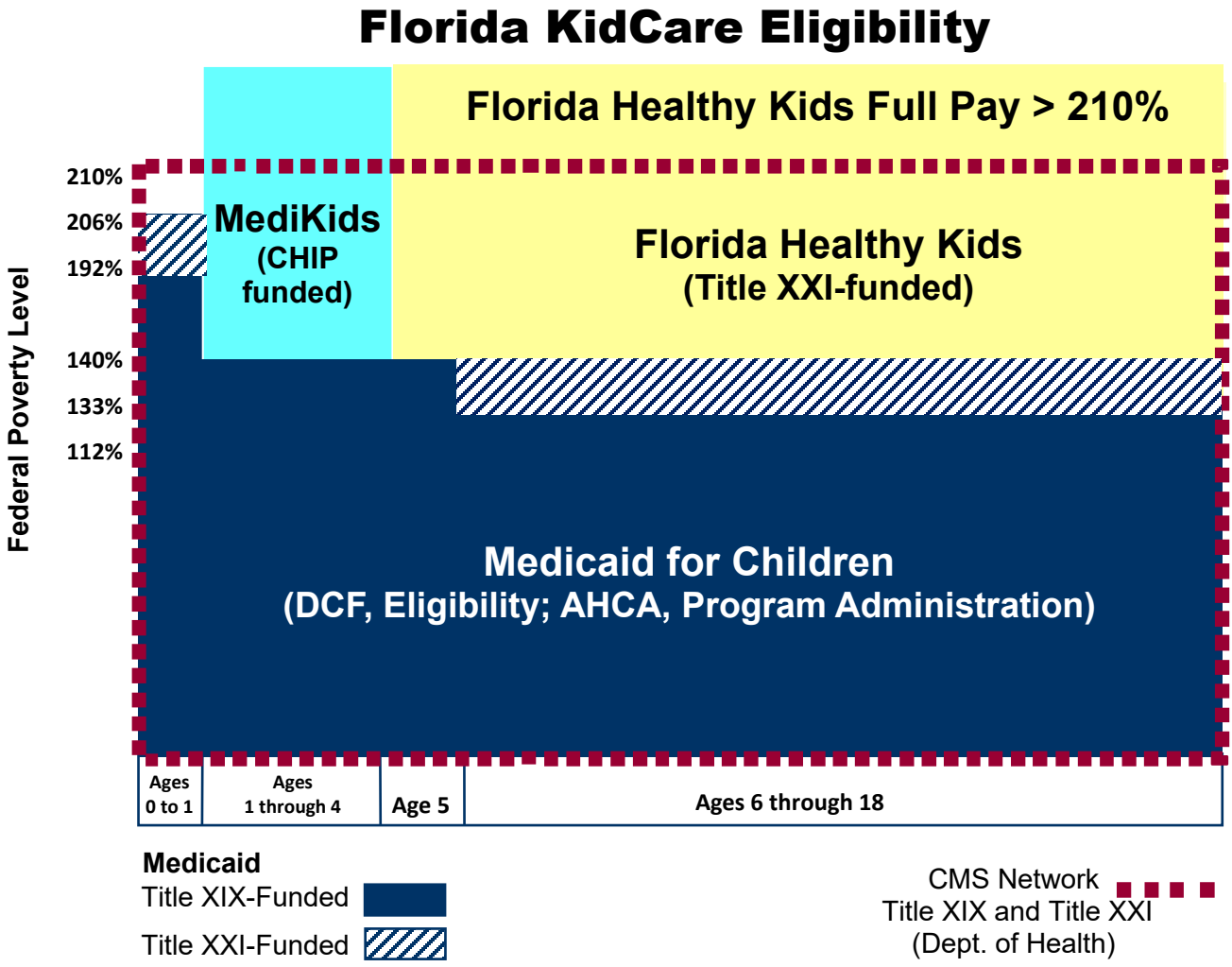
- Extending Medicaid coverage for children ages 15 to 19 in families with incomes up to 100% of the Federal Poverty Level;
- Expanding the Florida Healthy Kids program, modified to meet the requirements of Title XXI;

Phase 2 (*effective July 1, 1998*)

- Implementing the Florida KidCare program for children in families with incomes up to 200% of the federal poverty level, except for Medicaid. The components of the Florida KidCare program include:

- MediKids, ages 1 to 5;
- Florida Healthy Kids, ages 5 to 19;
- the Children's Medical Services Network for children with special health care needs, ages 0 to 19; and
- Medicaid for children under age 19.

- Initiating preventive dental coverage for selected sites for Florida Healthy Kids enrollees
- Converting children under the age of 1 in families with income up to 200% of the federal poverty level, to Title XIX Medicaid.
- Expanding comprehensive dental coverage for the Florida Healthy Kids program.



1.2 ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

Florida assures CMS that it will not claim expenditures for child health insurance prior to obtaining legislative authority to operate the CMS-approved plan amendment.

1.3 ☒ Check to provide an assurance that the state complies with all applicable civil rights requirements, including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date

The state assures that it complies with all applicable civil rights requirements.

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: July 1, 2018

Implementation Date: July 1, 2018

SPA #FL-19-00XX Purpose of SPA: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care and Revisions Related to Third Party Liability Final Rule – To demonstrate compliance with the CHIP Managed Care final regulations reflecting changes in the usage of managed care delivery systems.

Proposed effective date: July 1, 2018

Proposed implementation date: July 1, 2018

SPA #1 (MediKids and CMSN Expansion)
Effective date: July 1, 1998
Implementation date: October 1998

SPA #2 (Employer-sponsored Insurance)

Disapproved: November 5, 1999

SPA #3 (Healthy Kids Dental Pilot)
Effective date: October 1, 1999
Implementation date: October 1, 1999

SPA #4 (Expands Medicaid <1, MediKids Mandatory Assignment)
Effective date: July 1, 2000
Implementation date: July 1, 2000

SPA #5 (Expands Healthy Kids Dental Coverage)
Effective date: February 1, 2001
Implementation date: February 1, 2001

SPA #6 (School-based Health Services)
Effective date: July 1, 2002
Implementation date: July 1, 2002

SPA #7 (Employer-Sponsored Coverage)
SPA Withdrawn

SPA #8 (Compliance)
Effective date: February 7, 2003
Implementation date: July 1, 2002

SPA #9 (Legislative Changes)
Effective date: July 1, 2003 & December 1, 2003
Implementation date: July 1, 2003

SPA#10 (PIC Services)
Effective date: March 11, 2004
Implementation date: March 11, 2004

SPA#11 (Change in Source of State Funding)
Withdrawn: April 10, 2006

SPA#12 (Legislative Changes)
Effective date: April 1, 2004 and July 1, 2004
Implementation date: April 1, 2004 and July 1, 2004

SPA#13 (KidCare Policy Changes)
Effective date: September 14, 2004
Implementation date: September 14, 2004 and March 12, 2004

SPA#14 (Hurricane Premium Credits)
Effective date: September 1, 2004
Implementation date: September 1, 2004

SPA#15 (Legislative Changes)
Effective date: December 21, 2004
Implementation date: December 21, 2004

SPA #16 (Legislative Changes)
Effective date: June 1, 2005
Implementation date: June 10, 2005

SPA #17 (Policy Clarifications)
Effective Date: October 1, 2006
Implementation Date: October 1, 2006

SPA #18 (Legislative Changes)
Effective Date: July 1, 2009
Implementation Date: July 1, 2009 and October 1, 2009 (for removal of limitations for mental health and substance abuse services)

SPA #19 (CHIPRA Dental Compliance)
Effective Date: July 1, 2010
Implementation Date: July 1, 2010

SPA #19 (Legislative Changes and Improvements)
Effective Date: July 1, 2011

SPA #20 (Legislative Changes and Improvements)
SPA Withdrawn: January 31, 2012

SPA #21 (Legislative Changes and Improvements)
Effective Date: July 1, 2011
Implementation Date: July 1, 2011

SPA #22 (Legislative Changes and Clarifications)
Effective Date: July 1, 2012
Implementation Date: July 1, 2012

SPA #23 (Provisional Eligibility)
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

SPA #24 Temporary Renewal Grace Period Extension
Effective Date: August 1, 2014
Implementation Date: August 1, 2014

Superseding Pages of MAGI CHIP State Plan Material

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
FL-13-0001 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS7 CS10 CS10 CS15	Eligibility – Targeted Low Income Children Eligibility – Special Program for Children with Disabilities Children With Access to Public Employee Coverage Maintenance of Agency Contribution MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3: Supersede all Sections 3.1, 3.2, 4.1.6, 4.1.9, 4.3 and 4.4.1: Supersede Information on Children's Medical Services Network Section 4.4.1: Supersede information on dependents of employees of a public agency Appendix: Supersede current documentation Section 4.3: Add new subsection and supersede information on income eligibility and methods Appendix A: supersedes all
FL-13-0002 Effective/	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Implementation Date: January 1, 2014				
FL-13-0003 Effective/ Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
FL-13-0004 Effective/ Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21 CS27	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number Substitution of Coverage Non-Payment of Premiums Continuous Eligibility	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4 Supersedes the current section 8.7 Supersedes the current section 4.1.8

SPA #25 Monthly Premium Conversion and Prospective Payment System

Effective Date: July 1, 2014

Implementation Date: July 1, 2014

Premium change to Modified Adjusted Gross Income (MAGI) conversion will be retroactive to January 1, 2014.

The Medicaid Prospective Payment System was implemented October 1, 2009. SPA #25 is updated to include this policy.

SPA FL-15-0026-CHIP, CS7 (Changes to Program for Children with Disabilities)

Effective Date: May 1, 2015

Implementation Date: May 1, 2015

SPA FL-16-0027-CHIP, CS18 (CHIPRA Section 214 for Lawfully Residing Children)
Effective Date: July 1, 2016
Implementation Date: July 1, 2016

SPA FL-17-0028-CHIP (Disaster Relief –To implement provisions for temporary adjustments to enrollment and renewal policies and cost sharing requirements for children in families living and/or working in Governor or FEMA declared disaster areas. In the event of a natural disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or renewal policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas.)
Effective Date: September 1, 2017
Proposed Implementation Date: September 7, 2017

SPA FL-17-0029-CHIP (Mental Health Parity and Addiction Equity Act (MHPAEA) - To implement the requirements of the Mental Health Parity and Addiction Equity Act of 2008 preventing group health plans and health insurance issuers from imposing less favorable benefit limitations on mental health or substance use disorder benefits.

Effective Date: October 1, 2017
Proposed Implementation Date: October 1, 2017

SPA #FL-19-0030-CHIP - Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care and Revisions Related to Third Party Liability Final Rule – To demonstrate compliance with the CHIP Managed Care final regulations reflecting changes in the usage of managed care delivery systems.

Proposed effective date: July 1, 2018

Proposed implementation date: July 1, 2018

SPA #FL-19-0031-CHIP - SPA withdrawn. The Florida Legislature removed provision from the state statute permitting the Florida KidCare Program to impose a $1 million maximum lifetime limit on covered benefits and services for children enrolled in the Florida Healthy Kids program.

SPA #FL-20-0032-CHIP - The state is revising the CHIP State Plan to include Disaster Relief Provisions for co-payments during a declared emergency.

Proposed effective date: March 9, 2020

Proposed implementation date: March 9, 2020

SPA #FL-2021-0033 Purpose of SPA: To demonstrate compliance with section 5022 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT Act) in areas related to coverage of behavioral health screening prevention and treatment services, strategies to facilitate use of appropriate screening and assessment tools and the requirement that these services be provided in a culturally and linguistically appropriate manner.

Proposed effective date: July 1, 2020

Proposed implementation date: July 1, 2020

SPA #FL-2021-0034 Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Proposed effective date: March 11, 2021

Proposed implementation date: March 11, 2021

1.4- TC Tribal Consultation (section 2107(e)(1)(C) Describe the consultation process that occurred specifically for the development and submission of the State Plan Amendment, when it occurred and who was involved.

SPA #21 – Proposed Effective Date: September 1, 2011
In accordance with out tribal consultation process described in Section 2.3-TC, letters were sent to the Seminole and Miccosukee Tribes on 9/7/2011 outlining the SPA changes. The letters ask that comments or questions be directed to Gail Hansen at the Agency for Health Care Administration.

SPA #22 –Effective Date: July 1, 2012
In accordance with our approved tribal consultation process described in Section 2.3-TC, the tribal notification letters were sent to the Seminole and Miccousukee Tribes on June 21, 2012, listing the SPA changes. The letters asked that comments be directed to Gail Hansen at the Agency for Health Care Administration. The letters advised the tribes that no response would be

interpreted as they had no comments. No response was received from either tribe.

SPA #23 – Effective Date: October 1, 2012
In accordance with our approved tribal consultation process described in Section 2.3-TC, the tribal notification letters were sent to the Seminole and Miccosukee Tribes on August 13, 2012, listing the SPA changes. The letters asked that comments be directed to Gail Hansen at the Agency for Health Care Administration. The letters advised the tribes that no response would be interpreted as they had no comments. No response was received from either tribe.

SPA #24 – Effective Date: August 1, 2014
In accordance with our approved tribal consultation process described in Section 2.3-TC, the tribal notification letters were sent to the Seminole and Miccosukee Tribes on June 18, 2014, describing the SPA changes, The letters asked that comments be directed to Gail Hansen at the Agency for Health Care Administration. The letters advised the tribes that no response would be interpreted as they had no comments. No response was received from either tribe.

SPA #25 – Effective Date: July 1, 2014
In accordance with our approved tribal consultation process described in Section 2.3-TC, the tribal notification letters were sent to the Seminole and Miccosukee Tribes on December 10, 2014, describing the SPA changes. The letters asked that comments be directed to Gail Hansen at the Agency for Health Care Administration. The letters advised the tribes that no response would be interpreted as they had no comments. On December 28, 2014, the Seminole Tribe requested further clarification. The requested clarification was provided on December 28, 2014. On December 31, 2014, a follow-up question was received, and a response was provided on December 31, 2014. No further comments or requests were received.

SPA #26, CS7 - Effective Date: May 1, 2015

This SPA clarifies changes to the Program for Children with Disabilities. The tribal notification letters were sent to the Seminole and Miccosukee Tribes on May 21, 2015, describing the State Plan Amendment changes. The letters advised the Tribes that no response would be interpreted as the Tribes having no comments.

No further comments or requests were received.

SPA#27 -Effective Date: July 17, 2016

This SPA clarifies lawfully residing children may receive CHIP coverage and will no longer be subject to a five-year waiting period as provided under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The tribal notification letters were

sent to the Seminole and Miccosukee Tribes on April 28, 2016, describing the State Plan Amendment changes. The letters advised the Tribes that no response would be interpreted as the Tribes having no comments

No further comments or requests were received.

SPA #28 - Effective Date: September 7, 2017

According to Florida's Tribal Consultation Policy, the state does not need to provide tribal consultation in the event that a SPA is not restrictive. In the event of a natural disaster, this SPA permits the State to notify CMS that it intends to provide temporary adjustments to its enrollment and/or renewal policies and cost sharing requirements, the effective and duration date of such adjustments, in the applicable Governor or FEMA declared disaster areas.)

SPA #29 - Effective Date: October 17, 2017

According to Florida's Tribal Consultation Policy, the state does not need to provide tribal consultation in the event that a SPA is not restrictive. This SPA implements the requirements of the Mental Health Parity and Addiction Equity Act of 2008 preventing group health plans and health insurance issuers from imposing less favorable benefit limitations on mental health or substance use disorder benefits.

SPA #30 - Effective Date: July 1, 2018

This SPA demonstrates compliance with the CHIP Managed Care final regulations reflecting changes in the usage of managed care delivery systems. The tribal notification letters were sent to the Seminole and Miccosukee Tribes on June 4, 2019, describing the State Plan Amendment changes. The letters advised the Tribes that no response would be interpreted as the Tribes having no comments. On June 11, 2019, the Seminole Tribe requested further clarification. The Agency provided clarification on June 18, 2019.

No further comments or requests were received.

SPA #31 - Effective Date: SPA Withdrawn

SPA #32 - Effective Date: March 9, 2020

According to Florida's Tribal Consultation Policy, the state does not need to provide tribal consultation in the event that a SPA is not restrictive. This SPA provides the state with an option

to waive cost sharing during a state of emergency. The SPA is not restrictive, and therefore did not require Tribal consultation."

SPA #33 - Effective Date: July 1, 2020

The State issued Tribal Correspondence to the Seminole and Miccosukee Tribes of Florida on May 28, 2021, describing the amendment. The State received no feedback regarding this amendment.

SPA #34 - Effective Date: March 11, 2021

According to Florida's Tribal Consultation Policy, the state does not need to provide tribal consultation in the event that a SPA is not restrictive. This SPA demonstrates compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under

public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

Insured Children

Almost 2.8 million of Florida's 3.6 million children under age 19 are insured. Females represent 49 percent of insured children and males represent 51 percent. White children account for 80.4 percent of insured children under age 19, and non-whites account for 19.6 percent.

At the inception of the Florida KidCare Program, the state lacked sufficient information about the distribution of the insured by geographic region. However, the 1998 Legislature authorized funding for a comprehensive health care study, the primary goal of which was to update the estimates of Florida's insured and uninsured populations. This study included information on insurance and uninsurance status by geographic region, race and ethnicity, employment and income level, the extent of dependent coverage, and type of coverage employees select. (See updated information from the insurance study, on page 10)

Uninsured Children

Florida has one of the nation's largest uninsured populations. An estimated 12.1 percent of Florida's 4.4 million children under age 19 are uninsured. Of the approximately 646,430 uninsured children, males represent slightly more than one half (53 percent). Whites account for 42.1 percent, African Americans account for 19.3 percent, Hispanics account for 36.3 percent, Asian and Pacific Islanders account for 2.2 percent, and Native Americans account for less than 0.1 percent. As a consequence, uninsured children are typically treated for urgent or emergent conditions in inappropriate settings and do not share the continuity of care enjoyed by their insured peers.

Most of Florida's uninsured children — 42 percent — reside in the southern part of the state. Thirty-six percent reside in Central Florida counties, and 22 percent reside in North Florida. Estimates of the uninsured children by geographic region were obtained by assuming that the statewide uninsurance rate of 23 percent is equally distributed among all 67 Florida counties. These estimates were derived from the 1993 RAND survey and updated by population estimates from Florida's Joint Legislative Management Committee, Division of Economic and Demographic Research, the *1997 Florida Statistical Abstract*, and the Urban Institute's *State-Level Data Book on Health Care Access and Financing*.
art of Florida's high uninsurance rate can be attributed to the characteristics of the state's business economy. Larger firms are more likely to offer health insurance as a benefit than small firms. More than 95 percent of Florida's businesses employ fewer than 25 individuals.

Health Insurance and Access to Care

Access to health care is crucial to a child's development. Children who have health insurance are more likely to receive preventive care — care that helps keep them in good health. Children who lack affordable access to a doctor are less likely to seek treatment for minor illnesses, suffering until the body heals itself or the condition becomes too severe for home treatments. For many children, the emergency room is their primary source of care. The Centers for Disease Control in 1991 reported that, for 13 percent of children ages 15 and under, hospital outpatient departments were their primary contact for health care services.

Another study found that uninsured children under the age of 19 are eight times more likely to receive care in an emergency room than children with insurance. This type of care is devastating to the child. The severe outcomes of these medical conditions reduce the child's ability to attend school and participate in the activities of a normal childhood. The costs associated with this level of care are not limited to the child, but affect the community as a whole. Emergency room services are expensive, especially when they are used to treat illnesses that could have been prevented by an earlier visit to a physician. According to the *Journal of the American Medical Association*, lack of health care coverage is an important factor in the delay of seeking preventive and acute care. Children with health insurance are more likely to be fully immunized, have more preventive care visits, fewer physician office visits for illnesses and fewer emergency room visits. For children with a regular source of care, total health care costs are lowered by 25%.

Prior to the inception of Florida KidCare, the structure of health insurance programs left more than 823,000 Florida children uninsured. This problem was partly a result of the system of employment-based health insurance. Although no single approach can solve the problems, Title XXI funding for the Florida KidCare program significantly reduced the number of uninsured children.

The Institute for Child Health Policy released their Statewide Children's Health Insurance Survey dated June 2002. The results show that approximately 15% of Florida's children are currently uninsured. The figures varied by federal poverty level (FPL) and have increased in both the less than 100% FPL category and the greater than 200% FPL category.

The Urban Institute and Kaiser Commission on Medicaid and the Uninsured, based on estimates from the March 2002 and 2003 Current Population Surveys, determined that 16% of Florida's children are currently uninsured.

Florida KidCare Law

The 1998 Legislature enacted the Florida KidCare Act, which dramatically enhances child health insurance options under Florida's Title XXI child health insurance plan. Florida KidCare consists of the following components:

- MediKids, a Medicaid "look-alike" program for children ages 1 to 5;

- Healthy Kids for children ages 5 to 19;
- The Children's Medical Services Network (CMSN) for children ages 0 to 19 who have a special health care need; and
- Medicaid for children under age 19.

Except for Medicaid, financial eligibility for the Florida KidCare program is 200 percent of the federal poverty level. Except for Medicaid, the Florida KidCare program is not an entitlement and participants contribute to the cost of their monthly premiums. The KidCare law also provides for six months of continuous eligibility for coverage.

The 2000 Florida Legislature authorized the following changes affecting the Title XXI Florida KidCare Program:

- Funding for 102,000 additional children in KidCare
- Mandatory Assignment for MediKids: This is a vehicle that is not intended to restrict enrollee choices. It is a measure to speed up the actual enrollment process by assuring a provider choice is made.
- Medicaid Expansion for Children Under Age 1: This is an expanded Medicaid eligibility for children under the age of 1 to 200% of poverty. Medicaid covers children under age 1 up to 185% FPL, and the Medicaid expansion for children under Age 1 covers children from 185% FPL to 200% FPL. These children are not included in the MediKids program, as MediKids covers children ages one through four.
- Expedited eligibility for KidCare program components: This authorized each of the KidCare partners to seek innovative measures to speed up the eligibility process.
- Implementing a comprehensive dental benefit program for the Florida Healthy Kids Corporation for counties that contribute at least $4,000 annually in local match funds, effective February 1, 2001. The Corporation began a staggered implementation of this program to eligible counties on February 1, 2001.

The 2001 Florida Legislature further amended the Florida KidCare program in the following areas:

- Removed the $4,000 local match requirement in order to have a comprehensive dental program in the Healthy Kids program. Healthy Kids was then required to expand this benefit statewide by June 30, 2002.
- Waived any local match requirements for the Healthy Kids program for the 2001-2002 state fiscal year.

The 2002 Florida Legislature amended the Healthy Kids' enabling statute, the Florida Healthy Kids Corporation Act, in order to address the issue of local match and to prescribe a specific

formula for the calculation of match only on Healthy Kids' non-Title XXI enrollees. The 2002 Legislature also provided $33.8 million in additional state funds to meet projected enrollment needs during the 2002-2003 state fiscal year.

The 2003 Florida Legislature made several statutory changes to the Florida KidCare Program's enabling legislation and adjusted the funding for the Florida KidCare Program based on several program modifications including:

- Effective July 1, 2003, the family premium payment increased from $15 per family per month to $20 per family per month for all Florida KidCare Program components (non-Medicaid). Effective January 1, 2004, a tiered monthly premium system will be implemented as follows: the family premium will be $15 for families with income less than or equal to 150% of the federal poverty level and $20 for families with incomes above 150% to 200% of the federal poverty level ($5 credits were provided in January to those families whose incomes were less than or equal to 150% of the Federal Poverty Level for each month of coverage their children had received between August 2003 and December 2003);

- Effective July 1, 2003, dental benefits were capped at $750 per enrollee per year (July 1 – June 30) for children enrolled in the Florida Healthy Kids program; and,

- Effective October 1, 2003, co-payments are increased from $3 to $5 for certain health care services for children enrolled in the Florida Healthy Kids program.

In addition to the statutory changes, the 2003 Florida Legislature eliminated funding for outreach for the KidCare Program, and appropriated funds that will limit enrollment to the June 30, 2003 enrollment levels.

The 2004 Florida Legislature made several statutory changes to the Florida KidCare Act, as follows:

- Provides an interim appropriation for SFY 2003-2004 to fund the enrollment of children who were on the wait list on or before March 11, 2004;

- Restricts application processing and enrollment for the Florida KidCare Program to no more than two 30-day open enrollment periods per year, in September and January, subject to available funding;

- Applications for the KidCare program, except Medicaid, will be accepted and processed only during open enrollment periods; applications for Title XXI received outside of an

open enrollment period will not be processed and no wait lists will be maintained;

- Requires verification and proof of income supported by copies of any federal income tax return for the prior year, any wages and earnings statements (W-2 forms), and any other appropriate document;

- Changes eligibility criteria to include accessibility to employer-based insurance coverage and provides an affordability test allowing families whose coverage would exceed 5% of the family's income to continue to be eligible for KidCare;

- Excludes from eligibility any applicant who has voluntarily canceled employer-based coverage in the six months prior to application for Title XXI, provides an exception for children whose pre-existing condition would exclude them from their parents' employer-sponsored health insurance;

- Requires disenrollment from Title XXI Florida KidCare when the program is over-enrolled, except for those children enrolled in CMSN;
- Authorizes Children's Medical Services Network (CMSN) to enroll up to 120 additional children outside of open enrollment periods annually, within existing resources, and based on emergency disability criteria outside the open enrollment periods. CMSN is exempt from disenrollment provisions. Children will not be required to disenroll from other components to support the 120 CMSN enrollment slots;

- Modifies the Healthy Kids dental benefit language to require dental benefits coverage for Healthy Kids enrollees and further provides that the benefit may include all services available to children under Medicaid. Effective July 1, 2004 the dental premium rate capped at $12 per member per month;

- Provides for the withhold of benefits and prosecution of fraud for applicants and enrollees who submit fraudulent information or fail to provide evidence of eligibility;

- Establishes a 12-month continuous eligibility period, effective January 1, 2005;

- Changes the standards for Healthy Kids insurer contracting process; and

- Eliminates the statutory references related to outreach functions.

During the 2004 December special session, the Florida Legislature made a statutory change to the Florida KidCare Act, revising the income documentation requirement, as follows:

- Effective December 21, 2004, families are required to provide proof of income,

including a copy of the most recent federal income tax return. In the absence of a federal income tax return, the family may submit wages and earnings statements, W-2 forms, or other appropriate documents.

The 2005 Florida Legislature made several statutory changes to the Florida KidCare Act, as follows:

- Upon a determination from the Social Services Estimating Conference, applications for the Florida KidCare Program will be accepted at any time throughout the year for the purpose of enrolling children eligible for all Title XXI program components. Children will be enrolled on a first-come, first-served basis using the date the application is received. Enrollment will cease when the enrollment ceiling is reached. The enrollment ceiling is based on available funding. Enrollment will resume when the Social Services Estimating Conference determines sufficient federal and state funds are available to finance the increased enrollment through federal fiscal year 2007.

- The Florida KidCare application will be valid for a period of 120 days after the date it was received. At the end of the 120-day period, if the applicant has not been enrolled in the program, the application shall be invalid and the applicant shall be notified. The applicant may resubmit another application, or request that a previously submitted application be reactivated.

- Eliminates the provision that Children's Medical Services Network (CMSN) may enroll up to 120 additional children outside of open enrollment periods.

- Allocates up to $40,000 in state funds for the production and distribution of information about the Florida KidCare program through the school system. The materials are to be distributed on the first day of the 2005-2006 school year.

- Caps the dental premium rate for the Healthy Kids program at not more than $12 per member per month for the 2005/2006 state fiscal year.

The 2006 Florida Legislature made the following statutory changes to the Florida KidCare Act:

- Requires the Agency for Health Care Administration to implement a Full Pay buy-in program for MediKids-aged children by July 1, 2006.

- Allocates $1,000,000 in state funds for a KidCare community-based marketing and outreach matching grant program. No federal matching funds will be used.

The 2009 Florida Legislature made the following statutory changes to the Florida KidCare:

- Requires the marketing of the program as "Florida KidCare".

- Reduces the voluntary nonpayment of premium penalty from 60 days to 30 days.

- Allows children clinically eligible for Children's Medical Services Network to opt out of the CMS Network and instead be enrolled in MediKids or Healthy Kids, depending on the child's age.

- Waives the waiting period for enrollees who cancelled employer sponsored health insurance coverage prior to application if the cost of the coverage was greater than five (5) percent of the family's income.

- Reduces the waiting period from 6 months to 60 days, if health insurance is voluntarily canceled.
- Waives the waiting period for voluntary cancellation of health insurance coverage under certain good cause exceptions.
  Requires proof of income only if income cannot be determined or substantiated electronically.

- Allows 10 working days from an adverse action notice for enrollees to request reinstatement while pending a dispute resolution; clarifying that the timeline is working days rather than calendar days.

The 2010 Florida Legislature increased funding for the Florida Healthy Kids Corporation's dental plans and eliminated the annual benefit limit on dental services.

The 2011 Florida Legislature appropriated Title XXI funding for Full Service School Health Services in addition to the Comprehensive School Health Services already included.

The 2012 Florida Legislature made the statutory change to allow dependents of state employees who meet Title XXI eligibility requirements to receive subsidized Title XXI coverage.

In 2014 with the implementation of the Affordable Care Act changes and requirements, the grace period for renewals will be extended to 60 days to allow additional time for families to comply. This will promote continuity of care and avoid breaks in coverage. The 60 day grace period will be in effect from August 2014 through July 2015.

In 2014 with the implementation of the Affordable Care Act, the CHIP family premium levels have changed based on MAGI conversion. The upper income level for the $15 monthly family premium changes from 150% of the federal poverty level (FPL) to 158% FPL. The upper income level for the

$20 monthly family premium changes from 200% FPL to 210% FPL.

2.2 Health Services Initiatives – (formerly 2.4) Describe if the States will use the health services initiative option as allowed at 42 CFR 457.1005. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable, also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

School Health Services

Since July 2002, Title XXI administrative funds have been used to fund Comprehensive School Health Services. In recent years the Florida Legislature has limited the Title XXI funding to $7 million per year. Starting July 1, 2011, the 2011 Florida Legislature appropriated a total of $7.5 million using Title XXI administrative funds for Comprehensive and Full Service School Health Services. Increasing the number of counties therefore increases the number of students served which also increases the volume of the services provided by the school nurses. Full-service school health services do not duplicate services offered through SNAP and TANF. The same safeguards as explained in Section 3.1 will apply to Full Service School Health Services.

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):
Florida uses several programs to provide health care coverage to eligible low-income children:

Medicaid

The Agency for Health Care Administration is Florida's designated single state agency for the Medicaid program. The Department of Children and Families is Florida's designated Title IV-A agency and conducts Medicaid eligibility determination and enrollment functions.

Over half of Florida's 3.8 million Medicaid recipients are children — about 2.1million. Florida Medicaid covers children at the following income levels:

Age	Federal Poverty Level
0 to 1	192% (Title XIX)
0 to 1	above 192% - 206% (Title XXI Medicaid Expansion)
1 to 6	140%
6 to 19	133%
6 to 19	112% -133% (Title XXI Medicaid Expansion)

Managed care is an integral part of the Florida Medicaid program.

Florida has developed outreach brochures emphasizing Medicaid and other benefits for low-income working families and providing information on transitional benefits, including transitional Medicaid coverage for families leaving welfare for work. All materials are available in a variety of languages, reflecting the state's multicultural environment.

Florida Healthy Kids

Healthy Kids is another Florida KidCare component for uninsured children in Florida. As of July 1, 2005, this program provides coverage to more than 203,730 children, of which 177,721 are Title XXI eligible. Healthy Kids is authorized under section 624.91, *Florida Statutes*.

Initially, The Florida Healthy Kids Corporation (FHKC) used school districts to create large health insurance risk pools to bring affordable, accessible, quality private sector health care to the population of uninsured children.

- In the Healthy Kids program, the children themselves qualify for coverage.
- It is a solution for parents who are not offered employer-based health insurance.
- A child's coverage is not dependent on parents remaining employed.

With the implementation of Title XXI and the removal of the eligibility requirement that a child be enrolled in school in order to be eligible, Healthy Kids' relationship with the school districts has evolved; however, they remain a valuable partner in identifying eligible children and assisting with outreach efforts.

The problem of uninsured children is not exclusive to Florida — it is nationwide. Furthering its mission to assure that all Americans can acquire basic health care at a reasonable cost, from 1996 through 2001, the Robert Wood Johnson Foundation has made grant money available to replicate the Florida Healthy Kids program.

The importance of Healthy Kids is evident not only in the number of children who now receive health care, but also in the well-deserved recognition it has received. In December 1996, the FHKC received an Innovations in American Government Award from the John F. Kennedy School of Government at Harvard University and the Ford Foundation. Selected from 1,560 applicants, Healthy Kids was honored for its outstanding example of creative problem solving in the public sector. Additionally in 2001, the Innovations Program celebrated its 15th Anniversary and as part of its celebrations, they named the top 15 programs ever recognized and the Healthy Kids program was one of those distinguished programs.

Children's Medical Services Network

The Children's Medical Services Network (CMSN) and its area offices are located in the

Department of Health. The CMSN is statutorily authorized (Chapter 391, *Florida Statutes*) to operate the CMSN, which is a managed system of care for low-income children with special health care needs. For Title XXI-funded enrollees, the CMSN receives a monthly premium from AHCA. The CMSN is also an approved Medicaid managed care option for children with special health care needs and is the state's Title V agency for children with special health care needs. These children do not pay premiums. Staff in the CMSN area offices determine clinical eligibility for children with special health care needs.

The CMSN delivery system is a private provider network that includes local, regional and tertiary facilities and private health care providers. The delivery system incorporates a continuum of care that includes early intervention programs, primary and specialty care, and long term care. Providers and families are supported through a case management system. The provider network includes approved Medicaid providers and pediatric primary care physicians enrolled in Healthy Kids plans. The CMSN enters into contracts with providers to participate in the CMSN.

Children's Mental Health Services

Florida's Agency for Health Care Administration, the Department of Children and Families and the Department of Health work collaboratively to provide Medicaid-funded and state-funded mental health and substance abuse services for children through networks of contracted providers. There is also an array of substance abuse services funded by Medicaid and the Department of Children and Families for children and adolescents with serious alcohol or other drug addictions.

Direct Health Services

Direct health services are provided by county health departments, school-based health centers and voluntary practitioner programs.

- Florida has 67 county health departments, which provide comprehensive primary care services, including care for acute and chronic illness, injuries, family planning, prenatal care, diagnostic services and prescriptions.
- . Some county health departments have agreements with managed care organizations to provide other Medicaid services.
- The county health departments furnish services on a sliding fee scale, according to family size and income.
- Maternal and Child Health Block Grant (Title V of the Social Security Act) funds are passed through to the county health department where they are used to support a number of activities on behalf of women and children, particularly those of low

income. State Title V staff provides oversight, consultation and standards to assure appropriate utilization of these funds. When families are ineligible for any insurance plan, or when there is not another provider of free or reduced price health care (i.e., community or rural health centers) available or accessible, many of these county health departments provide direct services to low-income children. Services provided in county health departments include comprehensive well child clinic services, including developmental and physical assessments, immunizations and parent education. Families under 100% of the Federal Poverty Level receive these services at no cost. Others pay on a sliding scale.

- The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutritious foods to supplement the regular diet of pregnant women, breastfeeding women, infants and children under age five who are at or below 185% of the Federal Poverty Level and who meet nutritional/medical risk criteria for eligibility. WIC staff encourages pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid.
- County health departments tell their clients about the Medicaid program and refer them to the local Department of Children and Families office for a full eligibility determination. County health departments also serve as presumptive eligibility sites for pregnant women and infants under age 1.

Healthy Start

Florida's Healthy Start service delivery model has proven to be an effective strategy for targeting risk reduction resources to pregnant women and infants most at risk for poor health and development outcomes. Prenatal and infant risk screening identify potential Healthy Start participants. Further in-depth risk assessment by trained staff and family support planning with clients ensures risk reduction services are targeted to at-risk pregnant women and infants. These services, which provide at-risk families with the information, encouragement and support needed to take control of their own health practices and choices, may be provided in the home, clinic, or other community settings.

Universal Healthy Start risk screening takes place at the first prenatal visit and before a newborn leaves the hospital, providing a unique opportunity to reach out to the populations whom could most benefit from Healthy Start services. Other outreach sites include WIC and Work and Gain Economic Self-Sufficiency (TANF) offices for welfare-to-work participants, Head Start and day care sites, and teen pregnancy/parenting programs.

Florida's locally-based Healthy Start Coalitions have been very successful in reinforcing the delivery of quality services through involving community partners in local needs assessment, service delivery planning and implementation and monitoring service

delivery. The Healthy Start Coalitions which do not provide health services are responsible for determining the allocation of state and federal maternal and child health funds for Healthy Start risk reduction services and for ensuring accountability for high-quality service at the local level, where monitoring and ongoing evaluation can best be accomplished.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Healthy Kids has contract arrangements with many school districts in order to facilitate the distribution of applications and other marketing materials through the schools each year. Many of the original school districts that became involved in Healthy Kids prior to Title XXI continue their own local efforts as well.

For the 2005/2006 SFY, the Legislature appropriated $40,000 in state funds to provide KidCare program information to all school children. This information will be distributed statewide on the first day of the 2005/2006 school year.

The following table indicates activities and the sharing of responsibilities in those counties with local efforts.

Function	FHKC or Its Third Party Administrator	School Districts	Health Plans
Outreach	X	X	
Participant Education	X	X	X
Enrollment	X		
Member Services	X		X

Outreach Enrollment forms and marketing materials are made available at participating county schools during open enrollment periods. The marketing activities, forms and associated materials are designed by the KidCare Partners and FHKC or provided by the Department of Health.

Participant Education Healthy Kids' contracted health and dental insurers also include activities such as: (1) basic education about accessing services and using the plan, and (2) innovative strategies for

meeting wellness care and immunization standards, as well as health promotion and prevention.

Enrollment

The enrollment process is a function of the Corporation or its third party administrator, which conducts Medicaid eligibility screening and referral, determines financial eligibility for Title XXI and verifies lack of enrollment in Medicaid and access to state employee benefits.

Member Services

The health and dental plans provide identification cards and membership handbooks detailing program benefits and the grievance process. The third-party administrator (TPA) and the health plan each have member services staff that provide assistance to families regarding eligibility, benefits and how to access services. Customer service representatives that are bi-lingual and other language translation services are also available. In addition, Healthy Kids provides an auto-dialer process, where software automatically calls families with recorded information in order to expedite processing and alert families that their payments are late.

Outbound telephone calls are also conducted for Healthy Kids families who are in the re-determination or renewal process for the program. Customer service representatives make phone calls to families reminding them of the importance of completing this process and providing assistance with the completion of the renewal document.

The FHKC is responsible for coordinated marketing of the Healthy Kids program. FHKC does not use commissioned insurance agents for marketing and enrollment.

One of the primary objectives of the marketing strategy is to keep the materials, both Healthy Kids specific information as well as general KidCare program information, simple to understand. As such, a goal for marketing materials is that they be written at a fifth grade reading level. For areas with a large concentration of non-English speaking populations, materials are prepared to fit their specific needs. Currently, the KidCare application and brochures are available in English, Spanish and Creole. In addition, FHKC's TPA employs a multi-lingual staff.

The school system is an integral component for the marketing of the program. As previously noted, most children attend school. The school systems already have in place an efficient distribution system. By sending brochures and applications home with the

children, FHKC can be assured that it is reaching its target population.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as Title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))
New Florida KidCare Program Applicants

Applications received through the mail are usually received at a Post Office Box in Tallahassee, Florida. The program also offers families an online application process as well. FHKC's third party administrator retrieves the mail from the post office on a daily basis.

Children who appear to be Title XIX eligible based on age, household and income indicators (after applying income disregards), according to the most recent Federal Poverty Guidelines, will be referred for full Medicaid eligibility determination. During open enrollment periods, children who are not eligible for Title XIX will be processed for enrollment in the appropriate Florida KidCare program component (MediKids, Healthy Kids, or the Children's Medical Services Network). Applications received outside an open enrollment period will not be processed for Title XXI coverage. Applicants will receive a letter informing them of the closed enrollment period and will direct them to re-apply during the next open enrollment period.

FHKC and/or its third party administrator conduct the following activities for all components of the Florida KidCare program (except Medicaid):

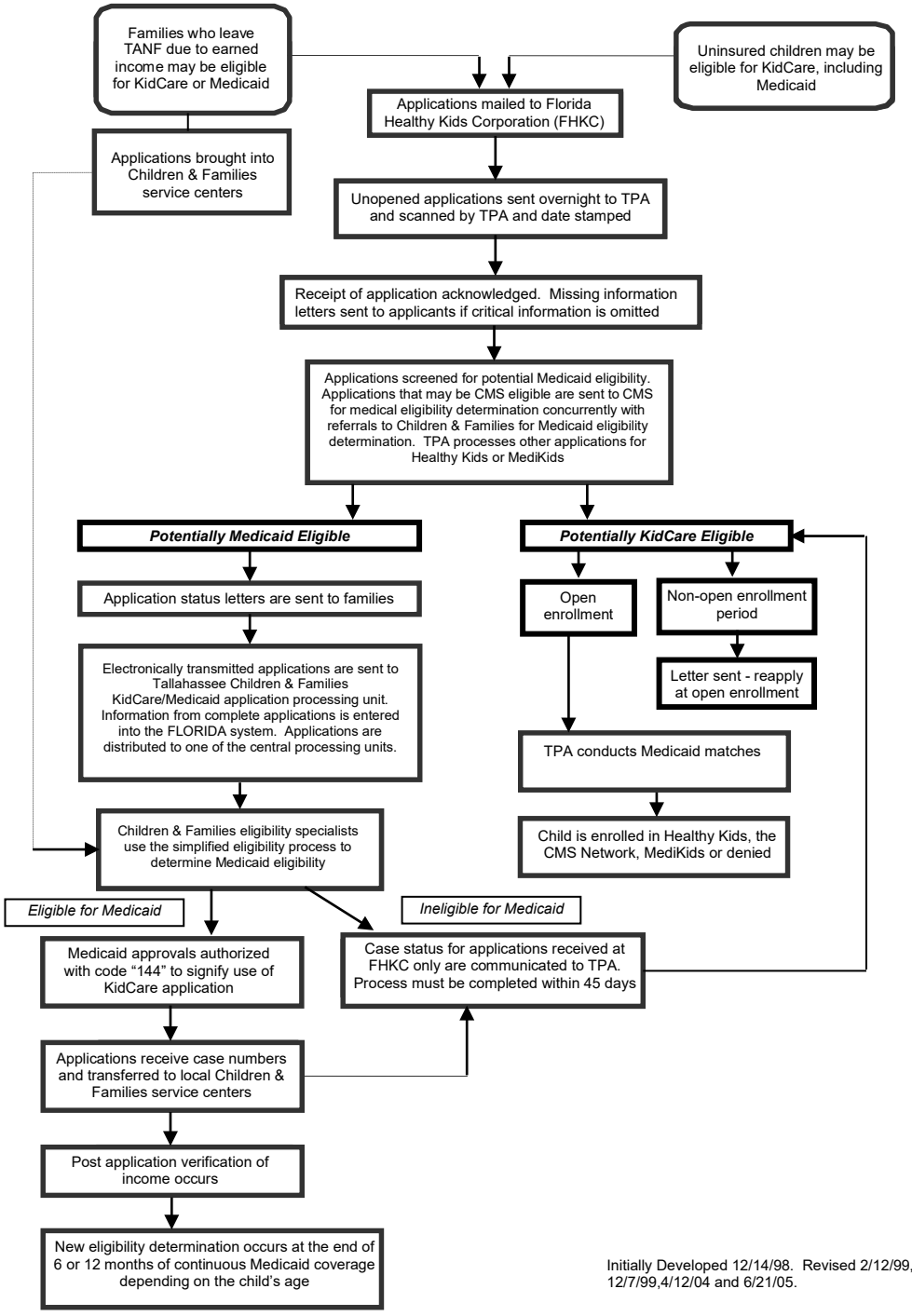
- accepting and processing Florida KidCare applications;
- conducting Title XIX screening of Florida KidCare applications;
- electronically transmitting application data for children who appear to be eligible for Medicaid to the Department of Children and Families eligibility determination workers for a full Medicaid eligibility determination;
- collecting monthly premiums from Title XXI families in accordance with the fee schedule, distributing coupon books to families, sending follow-up letters to families who have not made their monthly premium payments, and disenrolling children whose families do not make their monthly premium payment;
- making referrals to the Children's Medical Services Network (CMSN) of applicants or current enrollees who indicate their child has a special health care need;
- transferring a data file of MediKids eligibles to the Agency for Health Care Administration for choice counseling once an application is received from a potential MediKids enrollee; and

- notifying MediKids enrollees who attain the age of 5 that they will be enrolled in Healthy Kids at the first of the month following the month in which the child reached his fifth birthday, if space is available for such a transition.

Enrollment in a Florida KidCare program component will not occur until the following conditions are met after ineligibility for and non-enrollment in Medicaid is determined and financial eligibility has been established:

MediKids:	(1) the FHKC receives the premium payment, and (2) the family has made a choice of a managed care plan. **Healthy Kids:** FHKC receives the premium payment.
CMSN:	(1) the FHKC receives the premium payment, and (2) the Children's Medical Services Network confirms that the child meets the clinical eligibility criteria for participation in the Children's Medical Services Network. The Department of Children and Families determines clinical eligibility for children with serious behavioral or emotional conditions for Behavioral Health Network (BNET) services. Children enrolled in BNET receive their medical services through CMSN.

Florida KidCare Application Process



Initially Developed 12/14/98. Revised 2/12/99, 12/7/99,4/12/04 and 6/21/05.

Phase 1 Effective Date: April 1, 1998
Phase 2 Effective Date: July 1, 1998

Revised: 1/26/98, 2/19/98, 3/3/98, 3/6/98
Revised: 8/20/98, 8/24/98, 10/1/99, 7/28/00, 1/31/01, 7/02/02, 7/22/02, 1/3/03, 2/13/04, 9/27/04, 11/15/04, 8/11/05, 10/1/06, 7/1/09, 7/1/10, 7/1/11, 7/1/12, 10/1/12, 8/1/2014, 7/1/2014, 5/1/2015, 7/1/16, 9/1/2017, 10/1/17, 7/1/2018, 3/9/2020, 7/1/2020, 3/11/2021

Medicaid

Effective April 1, 1998, Florida extended Medicaid eligibility to children ages 15 to 19 with family incomes up to 100 percent of the federal poverty level. Eligibility is based solely on the child's age, household size and family income, as reflected in the Federal Poverty Guidelines. No asset tests were applied. The children in this expansion group aged out of the program as of October 1, 2002.

Effective July 1, 2000, Florida extended Medicaid eligibility as a Title XXI Medicaid Expansion program to children ages 0-1 with family incomes up to 200 percent of the federal poverty level. Eligibility is based solely on the child's age, household size and family income, as reflected in the Federal Poverty Guidelines. No asset tests are applied.

Effective July 1, 2004, the Department of Children and Families transfers to FHKC, a weekly file of children who are no longer eligible for Medicaid due to being over income or aging out. Families are mailed an EASY (Expedited Application Services for You) KidCare application. Families who return the EASY application along with the required documentation are processed for Title XXI coverage, regardless of whether or not the enrollment ceiling is reached.

Effective July, 1, 2009, the Department of Children and Families will transfer to FHKC, a nightly file of children who were denied or are no longer eligible for Medicaid due to being over income or aging out, to facilitate the transfer of children from Medicaid to Title XXI. The nightly file includes all of the data elements used by the Department of Children and Families to determine eligibility. A Title XXI eligibility determination will be made using the Medicaid data elements and other documentation as needed.

2.3-TC Tribal Consultation Requirements – (sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness, and process for seeking such advice.

The two federally recognized tribes in Florida are the Seminole and Miccosukee tribes. A letter was sent to each tribe on August 15, 2011, suggesting a consultation process for Title XXI State Plan Amendment changes. The suggested process includes sending a letter to each tribe 30 days in advance of amending the Title XXI State Plan, to offer them an opportunity to provide input on the proposed changes. Neither tribe responded to this letter; however, we will interpret this to mean they have no comments. The tribal consultation process assumes that the tribe does not have any comments if no response is received.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **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 4 (Eligibility Standards and Methodology).

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☒ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☐ No
☒ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

The following services are not provided by the Managed Care Plan, but are available to eligible Medicaid recipients through the Medicaid FFS delivery system (MediKids does not provide any waiver services):

1. Medical and Behavioral Services
2. Hemophilia Factor-related Drugs
3. School-based services provided by school districts
4. Newborn Hearing services
5. Prescribed Pediatric Extended Care services

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
  ☒ Capitation payment
  Describe population served: Children ages 1-4 enrolled in the MediKids program. Children 5-18 enrolled in the Florida Healthy Kids program, Children with special health care needs, ages 1-18, enrolled in the Children's Medical Services Plan.

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
  ☐ Capitation payment

☐ Other (please explain)
Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

☒ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
- ☒ Capitation payment
- ☐ Other (please explain)
  Describe population served: Children 5-18 enrolled in the Florida Healthy Kids program (dental services)

☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Other (please explain)

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
- ☐ Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line
☐ Development of enrollee care plans
☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
☐ Oversight responsibilities for the activities of FFS providers in the FFS program
☐ Provision of payments to FFS providers on behalf of the State
☐ Provision of enrollee outreach and education activities
☐ Operation of a customer service call center
☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement

☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
☐ Coordination with behavioral health systems/providers
☐ Other (please describe)

3.1.2.2 ☒ The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

☐ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal

agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.

- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 ☒ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 ☒ The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 ☒ The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

☒ Based on public or private payment rates for comparable services for comparable populations; and

☒ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

Guidance: States that checked both boxes under 3.3.1 above do not need to make the next assurance. If the state is unable to check both boxes under 3.1.1 above, the state must check the next assurance.

☐ If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

3.3.2 ☒ The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 ☒ The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 ☒ The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

☒ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
☐ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
☐ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittances but not a dental PAHP, please include this information.

If the answer to the assurance above is yes for any or all managed care entities, please answer the next assurance:

☐ The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that

summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 ☒ The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

☒ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 ☒ The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 ☒ The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

☒ Yes

☐ No

If the State uses a default enrollment process, please make the following assurances:

☒ The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

☒ The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 ☒ The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 ☒ The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 ☒ If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

☒ The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

☒ Yes
☐ No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

☒ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

☒ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

☒ The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;

- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 ☒ The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 ☒ The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 ☒ The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 ☒ The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 ☒ The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or

PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 ☒ The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:
- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
  - That oral interpretation is available for any language and written translation is available in prevalent languages;
  - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
  - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:
- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising

this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☒ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the

requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for emergency services; and
  - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process; and

- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

3.5.15 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in

door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).

3.5.16 ☒ The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 ☒ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.

3.5.18 ☒ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

Guidance: The State should also complete Section 3.10 (Program Integrity).

3.6.1 ☒ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☒ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☒ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete the remaining assurances in Section 3.6 (3.6.4 through 3.6.20.

3.6.4 ☒ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.5 ☒ The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

3.6.6 ☒ The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

3.6.7 ☒ The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 ☒ The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically

necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☒ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:
- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☒ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:
- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☒ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:
- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service

in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

3.6.14 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 ☒ The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 ☒ The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and

- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity's services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

3.6.17 ☒ The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 ☒ The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 ☒ The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 ☒ The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

3.7.1 ☒ The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers

and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.7 (3.7.2 through 3.7.9).

3.7.2 The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

- ☒ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
- ☒ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
- ☒ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
- ☒ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- ☒ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the subcontractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- ☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- ☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation

of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and

☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 ☒ The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 ☒ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 ☒ The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 ☒ The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 ☒ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☒ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete Section 3.9. States with PCCMs and/or PCCM entities should be adhering to the State's review process for benefits.

3.9.1 ☒ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☒ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☒ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to

adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

☒ Yes
☐ No

Guidance: Only states that answered yes to assurance 3.9.4 need to complete the next assurance (3.9.5).

3.9.5 ☒ The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 ☒ The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 ☒ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 ☒ The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 ☒ The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 ☒ The State assures that the notice of an adverse benefit determination explains:

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

3.9.11 ☒ The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 ☒ The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

☒ Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

☒ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

☒ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

☒ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

☒ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

☒ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☒ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 ☒ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 ☒ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 ☒ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☒ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☒ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☒ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☒ The State assures that if it offers an external medical review:

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

3.9.24 ☒ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

3.9.25 ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26 ☒ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 ☒ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

Guidance: The State should complete Section 11 (Program Integrity) in addition to Section 3.10.

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the first seven assurances (3.10.1 through 3.10.7).

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

☒ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;

☒ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and

☒ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☒ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☒ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☒ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor 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 rights of employees to be protected as whistleblowers;

- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 ☒ The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

3.10.6 ☒ The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 ☒ The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

3.10.8 ☒ The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))

3.10.9 ☒ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 ☒ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 ☒ The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

- ☒ Encounter data in the form and manner described in 42 CFR 438.818.
- ☒ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
- ☒ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- ☒ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- ☒ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
- ☒ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

- ☒ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))
- ☒ It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

☒ It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 ☒ The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 ☒ The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3).

Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

3.11.1 ☒ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 ☒ The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 ☒ The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

Guidance: **Only states with PCCMs**, or PCCM entities need to answer the next assurance (3.11.4).

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

☐ Yes
☐ No

Guidance: Only states with MCOs and states that answered yes to assurance 3.11.4 need to complete the next three assurances (3.11.5 through 3.11.7).

3.11.5 ☒ The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 ☒ The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 ☒ The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

Guidance: The State should complete Sections 7 (Quality and Appropriateness of Care) and 9 (Strategic Objectives and Performance Goals and Plan Administration) in addition to Section 3.12.

Guidance: States with MCO(s), PIHP(s), PAHP(s), or certain PCCM entity/ies (PCCM entities whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes - see 42 CFR 457.1240(f)) - should complete the applicable sub-sections for each entity type in this section, regarding 42 CFR 457.1240 and 1250.

3.12.1 Quality Strategy

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities need to complete section 3.12.1.

3.12.1.1 ☒ The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236.
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State

will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 ☒ The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 ☒ The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

3.12.1.4 ☒ The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 ☒ The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).

3.12.1.6 ☒ The State assures that it will submit to CMS:
- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☒ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:
- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 ☒ The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next two assurances (3.12.2.1.1 and 3.12.2.1.2).

3.12.2.1.1 ☒ The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

Guidance: A State may request an exemption from including the performance measures or performance improvement programs established by CMS under 42 CFR 438.330(a)(2), by submitting a written request to CMS explaining the basis for such request.

3.12.2.1.2 ☒ The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement,

sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: **Only states with a PCCM** entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.2.2.

3.12.2.2.1 ☒ The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 ☒ The State assures that it annually requires each MCO, PIHP, and PAHP to:

1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 ☒ The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.3.

3.12.3.1 ☒ The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).

3.12.3.2 ☒ The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.4.

☒ The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for comment, has identified performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5 and 3.12.5.1.

☒ The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 ☒ The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 ☒ The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next three assurances (3.12.5.2.1 through 3.12.5.2.3). Under 42 CFR 457.1250(a), the State,

or its agent or EQRO, must conduct the EQR-related activity under 42 CFR 438.358(b)(1)(iv) regarding validation of the MCO, PIHP, or PAHP's network adequacy during the preceding 12 months; however, the State may permit its contracted MCO, PIHP, and PAHPs to use information from a private accreditation review in lieu of any or all the EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

3.12.5.2.1 ☒ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 ☒ The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

3.12.5.2.3 ☒ The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

Guidance: Only states with PCCM entities need to complete the next assurance (3.12.5.2.4).

3.12.5.2.4 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart

D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5.3.

3.12.5.3.1 ☒ The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 ☒ The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 ☒ The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

3.12.5.3.4 ☒ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and

analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));

- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☒ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☒ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☒ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by

April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☒ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 ☒ The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 ☒ The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **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 5.

4.0 Medicaid Expansion

4.0.1 Ages of each eligibility group and the income standard for that group: Children ages 0 to 1 year of age with income from 186% FPL to 200% FPL.

4.1. Separate Program

The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

All applicants are provided a reasonable opportunity to provide documentary proof of citizenship or immigration status. All applicants have up to 120 days to meet all of the eligibility requirements and documentation, including citizenship and identity documentation and immigration status. During the 120 day period, if an applicant meets all other eligibility requirements, the applicant is provided a reasonable opportunity period to provide the outstanding citizenship and immigration documentation. When a determination is made that the applicant is otherwise eligible, the applicant is enrolled the following month. Enrollment for any eligible applicant begins the month following the eligibility determination. Coverage is not denied, delayed, or reduced during this reasonable opportunity period. If the applicant does not provide the citizenship or immigration documentation by the end of the 120 days, the applicant is terminated and coverage is discontinued effective the following month.

Children who are initially eligible for Medicaid as a "deemed newborn" will not have to provide citizenship documentation as deemed newborns are considered to have provided satisfactory documentation of citizenship and identity. Medicaid citizenship eligibility determinations will be considered acceptable proof of citizenship for Title XXI eligibility determinations. When a "deemed newborn" loses Medicaid eligibility,

the information that Medicaid determined citizenship is included on the Medicaid closure file that the Department of Children and Family Services sends to Florida Healthy Kids Corporation for the Title XXI eligibility determination.

Previous Medicaid's citizenship eligibility determinations will be considered acceptable proof of citizenship for Title XXI eligibility determinations.

Documents issued by a federally recognized Indian Tribe evidencing membership, enrollment in, or affiliation with a federally recognized tribe is satisfactory documentary evidence of a child's citizenship or nationality.

Florida verifies citizenship for children born in Florida through the Department of Health's Vital Statistics. Families may provide any of the acceptable forms of documentation listed in 42 CFR 435.407 for children not born in Florida or who have not been documented through a previously described method.

Once U.S. citizenship has been established it does not have to be verified again.

Non-citizens must provide the child's date of entry and USCIS number and proof of the child's immigration status. This information is verified through USCIS and a determination made whether the child is a qualified non-citizen. Non-citizens must verify their status at each annual renewal.

Florida is not currently using the Social Security Administration verification option.

4.1.1. ☒ Geographic area served by the Plan:

MediKids: Statewide

Healthy Kids: Statewide

CMSN : Statewide

Partners In Care (PIC) Services: PIC services will be limited to counties participating in the Program for All-Inclusive Care for Children (PACC) Demonstration. These counties are: Baker, Clay, Duval, Nassau, St. Johns, Pinellas, Glades, Hendry, Lee, Escambia, Okaloosa, Santa Rosa, Walton, Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union,

Citrus, Hernando, Lake, Marion, Sumter, Dade, Monroe, Palm Beach, Orange, Osceola and Seminole.

4.1.2. ☒ Age:

Medicaid Expansion: 0 to 1

MediKids: 1 to 5

Healthy Kids: 5 to 19 Initially, Healthy Kids allowed the younger siblings of its enrollees to elect Healthy Kids coverage. Beginning May 1, 2002, no counties currently offer this option. No new enrollees under the age of 5 were allowed after this date and only those who applied previously were grandfathered in with coverage.

CMSN: 1 to 19 for children with special health care needs

Effective July 1, 2000, the Florida Legislature increased the income eligibility in Title XIX Medicaid for children ages 0-1 to 200% of the federal poverty level. All children under the age of 1 enrolled in MediKids and CMSN for June 2000 were transferred to Medicaid with no interruption in coverage.

PIC Services: Same as CMSN.

4.1.3. ☒ Income:

In an effort to ensure Florida KidCare uses the most family friendly approach to application processing, we use a bi-level approach to applying review standards. Applications are initially processed using the same family size, income guidelines and disregards as Title XIX Medicaid. If the results are that the child is found ineligible for Title XIX then the application is refigured, based upon gross household size and gross income. For specific information, please see the Screening Tool in Attachment A.

Florida uses no resource tests in determining eligibility. The 2004 State Legislature modified the Florida KidCare Act to require income documentation supported by copies of any federal income tax return for the prior year, any wages and earnings statements (W-2 forms), and any

other appropriate document, beginning July 1, 2004. This requirement will apply to all new applicants after this date and to current enrollees at their redetermination date.

Households are required to include income information on the KidCare application and provide documentation of income. If a household member is not listed in the income section of the KidCare application, it will be presumed that the unlisted person has no income. Application instructions state to write "none" if no household member has income.

Effective July 1, 2009, income will be verified electronically first and only if electronic verification is not available or is not able to substantiate the income reported by the family, will a request be sent for written documentation. Electronic verification of income may be obtained from various sources including Medicaid. Wage and unemployment compensation data may be received electronically from Florida's Agency for Workforce Innovation and the Florida Department of Revenue. Private vendors may also be used to verify a family's income. If income cannot be electronically verified, then the family will need to provide wages and earnings statements or pay stubs, W-2 forms, or a copy of their most recent federal income tax return.

Effective July 1, 2009, the family's attestation of income will be accepted for the MediKids and Healthy Kids Full Pay components. Effective July 1, 2009, access to employer-sponsored coverage is no longer a factor of eligibility based on changes to state law.

Effective July 1, 2009, a child will not be eligible if employer-sponsored or private coverage was voluntarily canceled within 60 days prior to applying for Title XXI funded coverage. Good cause exceptions to the 60 day wait are listed in Section 4.1.7.

MediKids: There are no income limitations for participation. Premiums are subsidized through Title XXI for participants at or below 200% of the Federal Poverty Level with no asset tests. Children with income over 200% of the Federal Poverty Level may enroll in the MediKids Full pay program, paying the entire cost of the premium. No state or federal funds are used.

Healthy Kids: There are no income limitations for participation. Premiums are subsidized through Title XXI for participants at or below 200% of the Federal Poverty Level with no asset tests. Children with income over 200% of the Federal Poverty Level may enroll in the MediKids Full pay program, paying the entire cost of the premium. No state or federal funds are used.

CMSN: 200% of the Federal Poverty Level with no asset tests for premium subsidies.

PIC Services: Same as CMSN

Medicaid Expansion: For infants under 1 year old, enrolled in the Medicaid expansion program, from the current Medicaid Title XIX funded income limit of 185% of the Federal Poverty Level to 200% of the Federal Poverty Level. There are no premiums and no asset tests.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

Florida KidCare uses no resource tests in determining eligibility.

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in the state):

A child must be a U.S. citizen or qualified alien for all of the Florida KidCare components (except emergency Medicaid services for illegal immigrants in compliance with Title XIX requirements).

A child must be a resident of the state of Florida in order to be eligible.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

MediKids: None.

Healthy Kids: None.

CMSN: State law provides that a child with a special health care need be referred to the CMSN; however, effective July 1, 2009, CMSN clinically eligible children may opt out of CMSN and enroll in MediKids or Healthy Kids, depending on their age. CMSN care coordinators will explain the benefits of CMSN enrollment invite providers, if they meet CMSN's credentialing requirements, to join the CMS Network, if opting out to keep a provider not in the CMS Network. Families opting out of CMSN will sign the Voluntary Opt Out form. There are no limits to the number of times a clinically eligible child can enroll in CMSN and opt out.

PIC Services: CMSN enrolled children who are or have been diagnosed with life threatening conditions, with or without complex psychosocial and familial problems, who are at risk of a death event prior to reaching 21 years of age will be eligible for participation in PIC. The CMS care coordinator will include in the medical, developmental, psychosocial assessments, additional assessment information to determine eligibility for PIC services. PIC services are only available to children enrolled in CMSN. Clinically eligible children opting out of CMSN cannot receive PIC services.

Since the CMSN is a PCCM model, each child has a primary care physician who provides or authorizes all services for the child. The CMSN care coordinator works in collaboration with the family/caregiver and the primary care physician as well as specialists. The CMSN care coordinator, after determining eligibility for PIC services, will contact the child's physician for his/her medical determination that the child is at risk for a death event prior to age 21 and could benefit from PIC services. Families will be offered the choice of participating in PIC. Upon receiving physician approval, the family/caregiver will be contacted by professional hospice staff that work with PIC to assess the child's needs for PIC services.

The enrollment goal for the Title XXI pilot program is to have approximately 150 children enrolled based on the following criteria: 50 will be newly diagnosed, 50 will be in the mid-stage of their life-threatening illness, and 50 will be at the end-of-their

life.

The CMSN is responsible for referring children for PIC services through a coordinated effort that includes the child's primary physician, specialist physicians and the family/caregiver. The child's primary care physician must certify that the child's condition could result in death prior to the age of 21 years and that the child/family/caregiver could benefit from PIC support services.

Possible diagnoses for children entering the PIC program may include: brain and spinal cord malformations, central nervous system degeneration and disease, infantile cerebral palsy, epilepsy, muscular dystrophies and myopathies, heart and great vessel malformations, cardiomyopathies, conduction disorders and dysrhythmias, respiratory malformations, chronic respiratory disease, cystic fibrosis, congenital anomalies, chronic renal failure, congenital liver disease and cirrhosis, inflammatory bowel disease, sickle cell anemias, hereditary anemias, hereditary immunodeficiency, human immunodeficiency virus disease, amino acid metabolism, carbohydrate metabolism, lipid metabolism, storage disorders, other metabolic disorders, chromosomal anomalies, bone and joint anomalies, diaphragm and abdominal wall anomalies, and other congenital anomalies.

4.1.7. ☒ Access to or coverage under other health coverage:

A child must be uninsured at the time of application for the Florida KidCare program.

Effective July 1, 2009, a child will not be eligible if employer-sponsored or private health care coverage was voluntarily canceled within 60 days prior to applying for Title XXI coverage. Claiming a good cause exception will be based on the parents' attestation. Good cause exceptions to the 60 day wait are including, but not limited to, the following situations:

1. The cost of participation in an employer-sponsored health

benefit plan is greater than 5 percent of the family's gross income;

2. The parent lost a job that provided an employer-sponsored health benefit plan for children;
3. The parent who had health benefits coverage for the child is deceased;
4. The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death;
5. The employer of the parent canceled health benefits coverage for children;
6. The child's health benefits coverage ended because the child reached the maximum lifetime coverage amount;
7. The child has exhausted coverage under a COBRA continuation provision;
8. The health benefits coverage does not cover the child's health care needs; or
9. Domestic violence led to loss of coverage.

State law provides an exception for children whose pre-existing condition would exclude them from participation in their parents' employer-sponsored coverage.

4.1.8. ☒ Duration of eligibility: Florida KidCare covers children up to age 19.

Florida law provides for six months of continuous eligibility for the Florida KidCare program. Effective January 1, 2005, enrollees will receive twelve months of continuous eligibility. In addition:

MediKids: A child is eligible for Title XXI subsidies until the end of the month of the child's 5th birthday. The month following the child's fifth birthday, the child, if still eligible is transferred to the Healthy Kids program.

Healthy Kids: A child is eligible for Title XXI subsidies up to age 19.

CMSN : A child is eligible for Title XXI subsidies up to age 19.

4.1.9. ☒ Other standards (identify and describe):

All Partners: The Florida SCHIP requires social security numbers for applicants enrolling in Florida KidCare. This requirement is consistent with 42 CFR 457.340(b).

CMSN : A child must meet criteria indicating that the child has a special health care need. However, CMSN clinically eligible children may opt out of CMSN and enroll in MediKids or Healthy Kids, depending on their age.

Healthy Kids, MediKids and the CMSN :

Effective June 10, 2005, with the approval of year-round enrollment by the Social Services Estimating Conference, applications for Title XXI coverage are accepted continuously throughout the year. Year-round enrollment shall cease when the enrollment ceiling is reached. Enrollment may resume when the Social Services Estimating Conference determines sufficient federal and state funds are available to finance the increased enrollment through federal fiscal year 2007. Applications received during a closed enrollment period will be screened for Medicaid and referred to the Department of Children and Families if a child appears eligible. All other applicants will receive a letter informing them that enrollment is closed and to re-apply during the next open enrollment period.

Healthy Kids and MediKids: Effective July 1, 2004, state law provides for mandatory disenrollments on a last-in, first-out basis, if the programs are over-enrolled or exceed budget limits. Children enrolled in the CMSN are exempt from mandatory disenrollments.

Florida does not anticipate the need for mandatory

disenrollments. Each program is required to maintain reserves to accommodate transfers between programs and these reserve estimates are monitored by the state's Social Service Estimating Conference. There are protections in place so that each program manages its budget. Each program calculates an average cost per member per month to project the maximum number of children that can be enrolled within appropriated funding. In the unlikely event that mandatory disenrollments are imminent, such activity shall not occur until Florida KidCare notifies the federal Centers for Medicare and Medicaid Services (CMS).

In the event that enrollment exceeds allocated funds and mandatory disenrollment becomes necessary, the public will be notified by means of press releases, public notices and information posted on the Florida KidCare and Healthy Kids web sites. Children affected by mandatory disenrollments will be notified in writing, providing a minimum 30-day notice before the effective date of the disenrollment. The families affected by mandatory disenrollment will have the same appeal rights offered to all applicants or enrollees.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment.
(Section 2102)(b)(2)) (42CFR 457.350)

Florida KidCare General Requirements

Florida's KidCare law establishes the general eligibility requirements for all components of the Florida KidCare program. To be eligible for premium assistance with Title XXI funds, a child must: (1) be uninsured; (2) be ineligible for Medicaid; (3) not be covered by group health insurance; (4) not have voluntary cancelled employer-sponsored coverage in the last 60 days; (5) have family income at or below 200% of the federal poverty level; (6) be a U.S. citizen or qualified alien; (7) not be an inmate of a public institution or a patient in an institution for mental diseases; (8) be a Florida resident; and (9) be age-eligible.

Families will be required to provide proof of income if not available electronically.

Effective July 1, 2009, access to employer-sponsored coverage is no longer a factor of eligibility based on changes to state law.

No face-to-face interviews are required.

The Department of Children and Families will use its access to other state computer systems to verify income statements on the application form for the Medicaid eligibility determination process. If the child is not a U.S. citizen, additional information may be required from the family in order to determine whether the child meets the criteria to be considered a qualified alien for Title XXI coverage. An automated matching system will also verify that no applicant is currently enrolled in the Medicaid program prior to enrollment in a non-Medicaid component of the Florida KidCare program.

A Third Party Administrator (TPA) under contract with FHKC conducts the determination of eligibility for non-Medicaid components of the Florida KidCare program. The TPA is responsible for the following services: system development; application processing; account maintenance; customer service and eligibility determination.

The Title XXI and Title XIX programs use the same income disregards and family income definitions to determine eligibility to the extent shown in Attachment A, the Medicaid Screening Tool.

As part of the application process, applicants will be required to provide a social

security number for each child beginning with the distribution of the new KidCare application in the first quarter of 2003. For those children who do not yet have a social security number, processes are in place to address those situations, to avoid any lag in processing time.

An automated matching system has been established with Medicaid. Electronic matches are conducted twice a month t, to identify a child's enrollment in Medicaid. If the match indicates enrollment in Medicaid, the child's coverage will be cancelled or the child's application will be denied, whichever is appropriate.

Self-Declaration

Information included on a signed Florida KidCare application or renewal form or received through verbal or written correspondence is considered acceptable self-declaration of information for the following policy verification requirements.

Self-Declaration by the family is accepted for the following:

1. **Residency** – the family's statement is accepted that they reside in Florida. Post Office boxes, rural routes and other non-conventional addresses are accepted, provided the address is in Florida.

2. **Household size and composition** – the family's statement is accepted for the household size, composition and relationships.

3. **Resident of an institution** – the family's statement is accepted that the child is not incarcerated, an inmate in a public institution or a patient in an institution for mental diseases.

4. **Child is uninsured** – the family's statement is accepted that the child is not currently covered by other health insurance.

5. **Child has not voluntarily cancelled other health insurance in last 60 days** – the family's statement is accepted that other health insurance was not cancelled within the last 60 days prior to the date of application.

6. **If child cancelled other health insurance within the past 60 days** - the family's statement is accepted for claiming to meet one of the following good cause exceptions. Good cause exceptions to the 60 day wait are including, but not limited to, the following situations:

    a. The cost of participation in an employer-sponsored health benefit plan is greater than 5

percent of the family's gross income;

b. The parent lost a job that provided an employer-sponsored health benefit plan for children;

c. The parent who had health benefits coverage for the child is deceased;

d. The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death;

e. The employer of the parent canceled health benefits coverage for children;

f. The child's health benefits coverage ended because the child reached the maximum lifetime coverage amount;

g. The child has exhausted coverage under a COBRA continuation provision;

h. The health benefits coverage does not cover the child's health care needs; or

i. Domestic violence led to loss of coverage.

7. **Children who do not have an SSN** - the family's statement is accepted that they applied and provide the date of application for a SSN. The family's statement is accepted for the child's social security number.

8. **Child care expenses** – the family's statement is accepted if they incur child care expenses and the amount of this expense.

9. **Child's identity for children under age 16** – the family can sign the designated space on the KidCare application attesting to the identity of a child under 16 or provide a signed Identity Self-Attestation form as proof of the identity of a child under 16.

10. **Child Support payments** – The family's statement is accepted if the family pays child support and the amount of the payments.

11. **Loss of income** – the family's statement is accepted for the loss of income and termination of employment.

12. **Pregnancy and due date –** The family's statement regarding pregnancy and the due date is accepted for any female member of the household.

System Improvements

Florida KidCare partners initiated several improvements to the processing system to

streamline the program and to improve overall program efficiency.

- The Medicaid screening process was revised to count Social Security Income.

  Previously, Social Security benefits were not counted in the initial screen process, and as many as one-third of all KidCare referrals to DCF were denied and sent back to DHACS in the disposition file. Many of these "false positive" referrals eventually resulted in enrollment in CMSN, MediKids, or Healthy Kids. Children who were unnecessarily referred to DCF took longer to complete the process and also represented additional work and cost at DCF.

  Revising the Medicaid screen within the KidCare processing system to count Social Security benefits eliminates more than half of the false positive DCF referrals without negatively affecting the screen's basic integrity or accuracy. Reducing the number of false positives referrals lessens the time it takes to process applications and provides a more reliable basis for referring children to DCF for Medicaid evaluation.

- The Child's Social Security Number (SSN) is now a Required Data Element.

  Making a child's SSN a required element expedites the processing of applications, improves the efficiency of Medicaid referrals, and improves the feasibility of data interfaces. Those children who do not have an SSN, must provide the date they applied for the SSN in order to be considered for coverage.

- Florida KidCare is aligning the Medicaid and Title XXI eligibility rules.

  An important consumer issue currently facing the Florida KidCare program is maintenance of coverage for a child moving from Medicaid to one of the non-Medicaid Title XXI programs. To improve this process, KidCare now assesses family size, countable income, and income disregards for each KidCare program using the Medicaid formulas as described in Appendix A, KidCare Medicaid Screening Criteria.

- Matching Medicaid and Title XXI

To minimize the occurrence of dual enrollment in Medicaid and Title XXI, new applicants are matched daily to determine if they are receiving Medicaid benefits. Active Title XXI enrollees are matched two times a month. Enrollees have always been matched once a month, within the first ten days of the month, and starting 2011,

a second Medicaid match is conducted during the last week of the month, to identify Medicaid recipients newly approved. The Florida Healthy Kids Corporation has also implemented an eligibility review process whereby applicants and enrollees are selected for review through a random audit process. This quality assurance activity ensures that applicants and enrollees are enrolled in the appropriate programs.

Open Enrollment Processing and Time Frames

All Florida KidCare applications are mailed to the Florida Healthy Kids Corporation (FHKC) for processing. The Florida KidCare application will be valid for a period of 120 days after the date it was received. At the end of the 120-day period, if the applicant has not been enrolled in the program, the application shall be invalid and the applicant shall be notified. The applicant may resubmit another application or request that a previously submitted application be reactivated.

FHKC and/or its third party administrator (TPA) conducts a Title XIX pre-screening for all children who apply for Florida KidCare. Children who appear to be Title XIX eligible based on age, family size and income indicators (after applying income disregards), according to the most recent Federal Poverty Guidelines, are transmitted electronically to the Department of Children and Families and processed for full Medicaid eligibility determination. Applications of children who are not eligible for Medicaid are processed for enrollment in the appropriate Title XXI-financed Florida KidCare program component (MediKids, Healthy Kids, or the CMSN). The TPA screens and electronically transfers all applicable applications to either the Department of Children and Families staff or to its TPA on the same day the application arrives in the office.

Within 72 hours of receipt, the TPA will generate a letter to the families informing them that the application has been received and is being processed.

If any information is missing, the family is notified by letter at this time. There are two types of missing information: those that would not stop the application from being processed and those that would stop the application from being processed. An example of the types of information that would stop an application if missing includes the lack of a Social Security number (or date applied) for a child, the date of birth for a child, or an authorized signature allowing FHKC to conduct the eligibility determination. Any other minor missing information would result in a letter to the family requesting such information but *would not delay* the child getting coverage.

The TPA determines, based on age, income and special health care needs, the program for which each child in the family is eligible. The TPA sends a data file to the Agency

for Health Care Administration (AHCA) of all children who are eligible for the MediKids program for choice selection and a data file to the CMSN of all children who have indicated a special health care need on the application. The CMSN further screens each applicant in order to determine whether or not the child is clinically eligible for the program.

Families are notified of their effective date of coverage, if eligible, in approximately 4-6 weeks after receipt of a completed application.

MediKids

In addition to the general requirements, to be eligible for MediKids, children must be between the ages of 1 and 5 and not have a special health care need, which would make them eligible for the CMSN, unless the family has opted out of CMSN enrollment.

Children's Medical Services Network

The Florida KidCare application contains questions to indicate whether a child has a special health care need. A family who indicates a child has a special health care need will be referred to the CMSN for a clinical eligibility determination. A child who meets the CMSN eligibility criteria will be enrolled in the CMSN provided they meet all other Title XXI non-Medicaid eligibility criteria. A child who does not meet the CMSN eligibility criteria will be processed for enrollment in MediKids or Healthy Kids. In September 2002 the KidCare program field-tested a new Florida KidCare application that contains 3 questions related to each child applicant's health care needs. The questions serve as a screening tool to determine if the children are clinically in need of CMSN enrollment. The new application was distributed in early 2003.

Children who have serious emotional disturbance (mood, psychotic or anxiety disorders) or substance dependence problems will be referred to Children's Medical Services and Children and Families' local staff for a determination of eligibility for specialized behavioral health care services.

Effective July 1, 2009, CMSN clinically eligible children may elect to opt out of CMSN and enroll in MediKids or Healthy Kids, depending on their age.

Continuous Eligibility for the Florida KidCare Program

Through December 31, 2004, Florida's KidCare Act provided for six months of

continuous eligibility. Before the six-month eligibility period ends, a family is asked to verify that their income status has not changed in order to continue the child's eligibility. Families of children who remain eligible for the Florida KidCare program at the six-month redetermination are notified to continue making premium payments. Beginning July 1, 2004, at redetermination, families will be required to provide proof of income and an attestation regarding availability of employer-sponsored health insurance for their children in order to remain eligible for continued coverage.

Beginning January 1, 2005, children enrolled in the Title XXI programs will receive 12 months of continuous eligibility. Twelve months of continuous eligibility are provided as follows:

- To qualify for the 12 months of continuous eligibility the child must have been determined eligible for a subsidized premium at the time of application or renewal.
- For an applicant, the first month of coverage begins the 12 month continuous eligibility period.
- For a renewing family, the month following the renewal completion date begins the 12 month continuous eligibility period.
- To avoid interruptions in a child's health care, children will receive 12 months of continuous coverage regardless of changes in the child's circumstances, with the exceptions of turning age 19 and moving out of state. Screenings will be done on reported changes during the annual renewal process, or at the parent or legal guardian's request.
- When a family reports an income change that exceeds 200% of the federal poverty level, the child(ren) will receive the remainder of their 12 month continuous eligibility period with no change in their subsidized premium.
- The 12 month continuous eligibility period may be different for each family member if adding a new child. At the time of the next renewal cycle, all individuals will be placed on the same 12 month continuous eligibility period.

Renewal Process

Each family must have their eligibility redetermined every 12 months. The renewal form is mailed to the family two months prior to the month of renewal. The deadline to return the renewal form and the required documentation is the 10th of the month prior to the renewal month. For example: Renewal is due October 1, the notice is

mailed to the family the first week in August. The renewal form and documentation is due September 10th. A cancellation notice is mailed to the family the day after the renewal deadline if the renewal form and the documentation are not received. If neither the renewal form nor the documentation is received, coverage is terminated effective the next month. If the family returns at least one document, indicating their intention to comply, the family is given a one month grace period and coverage continues. Coverage is cancelled effective the next month if the remaining documentation is not returned during the one month grace period. In order to promote continuity of care and avoid breaks in coverage, beginning August 1, 2014 and continuing through July 31, 2015, families will be given a 60 day grace period when needed. The additional 30 days grace period will be given when current information is not available through electronic data matches or other reliable information contained in the family's account, in compliance with 42 CFR 457.343. When information is not available the family is sent a letter directing them to renew their eligibility online. The online account information is pre-populated with the most current account information. If the family cannot renew online, a pre-populated renewal form is sent to the family. A 60 day grace period will provide families, when needed, with additional time to complete their renewal and comply with the Affordable Care Act changes and requirements. During this process, the family will also receive autodialer calls as reminders.

An administrative renewal process will begin September 2011. Data matches will be conducted with the Department of Revenue and the Agency for Workforce Innovation the week prior to the renewal initiation period. If income data is available, the income sections of the renewal form will be pre-populated with this information. When the family receives the renewal form they can confirm the information is correct by either signing the paper form or accessing the website and completing the electronic signature. If the information is not correct or incomplete, the family will need to provide verification.

Disaster Relief Provisions

At the State's discretion, working collaboratively, and with the agreement of FHKC and/or CMS Plan, the State may take any/or all of the following actions for a specified period of time for enrollees living and/or working in a Governor or Federally declared disaster areas or state of emergency (i.e. pandemic):

- Waive premium payments.
- Allow additional time to:

  - Complete the renewal process.
  - Make premium payments.
- Waive or lower copayments

The AHCA will notify the CMS in the event of a declared disaster or state of emergency and Florida's intent to implement any or all of the policy modifications. The CMS notification will include the intent to implement modifications, the areas affected by the disaster and the effective dates of the policy modifications.

The next twelve-month continuous eligibility period begins the month after the renewal completion date.

Provisional CHIP Eligibility

In accordance with 42 CFR 457.350(g)(2) and 66 Federal Regulation 2548 (January 1, 2001) the State will provide provisional CHIP coverage up to 60 days for a child enrolled in CHIP and screened potentially eligible for Medicaid, provided the child continues to meet all of the CHIP eligibility requirements. DCF usually responds to CHIP referrals within one month; however if a response is not received within 60 days, FHKC will contact DCF to determine the reason for the delay. If additional time is warranted, CHIP coverage may be extended until DCF renders a Medicaid determination. When a CHIP child is identified as potentially Medicaid eligible during the screening process, a referral will be made to the Department of Children and Families for a full Medicaid eligibility determination. The child will receive provisional CHIP eligibility from the month of the Medicaid referral through the end of the month in which the Medicaid eligibility determination was rendered. If the child is determined Medicaid eligible, provisional CHIP coverage will be terminated effective the following month. The family will receive a disposition letter advising them that the child's CHIP coverage has been terminated due to Medicaid coverage and informed about the potential for Medicaid to cover unpaid medical bills during the retroactive eligibility period. If the child is determined not Medicaid eligible, the child's CHIP provisional coverage will end and regular CHIP coverage will continue, provided the child meets all factors of CHIP eligibility. The family will receive a disposition letter advising them that CHIP coverage will be continued.

Time Frame for Changes

When a change occurs that affects eligibility and/or the family premium, the family is notified by letter of the change and the effective date of the change. Premium and eligibility changes are handled as follows:

- Changes that reduce the monthly premium are effective the next month, regardless of when in the month the change occurs. For example: a change occurs on August 5 that reduces the monthly premium. The reduced premium will be due September 1 for October coverage. A change occurring August 25 which reduces the monthly premium will also be effective with the premium due September 1 for October coverage.
- Changes resulting in loss of eligibility, which are not subject to the 12 month continuous eligibility period, are effective the next month, unless the change occurs after the next month's eligibility file run date. Changes occurring after the eligibility file run date will be effective the month following the next month, to allow for adequate notice. For example: a change occurs August 5 which results in a loss of eligibility. Coverage is terminated effective September 1. A change occurring August 25 which results in a loss of eligibility will cause coverage to be terminated October 1. An exception to this policy is when the loss of eligibility is due to Medicaid coverage. When a Title XXI child is determined eligible for Medicaid, Title XXI coverage will be cancelled effective the month following the reported change.

- Changes resulting in a premium increase, which are not subject to the 12 month continuous eligibility period, are effective the next month, unless the change occurs after the next month's eligibility file run date. Changes occurring after the eligibility file run date will be effective the month following the next month, to allow for adequate notice. For example: a change occurs August 5 which results in an increase in the monthly premium. The increased premium will be due September 1 for October coverage. A change occurring August 25 which results in an increase in the monthly premium will be effective with the premium due October 1 for November coverage.

Fraud Provisions

The 2004 State Legislation also added provisions to the Florida KidCare Act to discourage fraud by applicants and enrollees in the program. The legislation allows the program to withhold benefits from any enrollee where evidence has been obtained indicating that incorrect or fraudulent information has been submitted, or the enrollee failed to provide information for verification of eligibility. Additional provisions are included for those found to have enrolled when the applicant knew or should have

known that the child was not eligible, or for those who assist others in committing fraud against the program. For those accused of fraud, the Medicaid fraud provisions in state law are to be utilized for prosecution.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

Effective July 1, 2003, each of the Florida KidCare components implemented a waiting list. The waiting list was eliminated as of March 11, 2004. Additional state funds were provided to extend coverage to those who entered the list on or before March 11, 2004. Applicants after that date were not processed for coverage and received a letter informing them to re-apply during the next open enrollment period. Effective June 10, 2005, the two annual open enrollment periods were eliminated by the Florida legislature and after approval by the state's Social Services Estimating Conference, Florida KidCare resumed accepting applications on a year-round basis. Year-round enrollment shall cease when the enrollment ceiling is reached. The enrollment ceiling will be determined by the amount of funding available. Florida will notify the federal Centers for Medicare and Medicaid (CMS) in the event that the enrollment ceiling is reached and enrollment has ceased. Year-round enrollment may resume when the Social Services Estimating Conference determines sufficient federal and state funds are available to finance the increased enrollment through federal fiscal year 2007. No waiting list currently exists and no future waiting lists will be maintained.

New legislation effective July 1, 2004, does allow for transfers among the KidCare program components so long as space and funding are available. The programs are directed to establish reserves so these transfers can be managed within existing funding. Florida will notify the federal Centers for Medicare and Medicaid (CMS) in the event that transfers are no longer allowed between programs. We do not anticipate the need for this to occur.

Enrollee Status	Transfer to Title XXI Coverage
New Applicants – Enrollment ceiling not reached	Yes
New Applicants – Enrollment ceiling reached	No

Current Title XXI Enrollee Transferring to New Title XXI Component	Yes
Current Medicaid Expansion Under 1 Year Old – Turning 1 Year Old and Losing Medicaid Eligibility	Yes
Current Title XIX Under 1 Year Old – turning 1 Year Old and Losing Title XIX Eligibility	Yes
Current Title XIX losing Title XIX Eligibility	Yes
Title XIX CMSN Eligible Losing Title XIX Eligibility & Transferring to Title XXI CMSN	Yes
Current Title XXI Enrollee who Misses a Premium Payment	Yes (after 30 days)
Previous Title XXI Enrollee with a break in Coverage Due to Reason Other than Non-Payment of premium	Yes

Families who do not pay their monthly premium on time will be disenrolled from coverage and will not be eligible for reinstatement for a minimum of 60 days, in accordance with state law. Effective July 1, 2009, children disenrolled due to voluntary non-payment of premium will be eligible for reinstatement after 30 days.

The following chart shows the minimum waiting period for cancellation due to non-payment of premium since the inception of the Florida KidCare program.

Effective Date of Policy	Waiting Period Before Reinstatement – For Cancellations Due to Non-Payment of Premium
July 1998 – December 2003	Minimum 60 day waiting period before reinstatement
December 2003 – October 2004	Minimum 6 month waiting period before reinstatement
October 2004 – June 2009	Minimum 60 day waiting period before reinstatement
July 2009 - Present	Minimum 30 day waiting period before reinstatement

At the end of any disenrollment period for non-payment of premium, the children will be reinstated, provided the premium has been paid prior to the end of the disenrollment period. Reinstated children receive coverage without being required to re-apply for the program; however, a reinstatement date may not be assigned until the family has complied with any new eligibility requirements.

In such instances when enrollment caps are reached or Title XXI enrollment is closed, applications will continue to be accepted and will be screened for potential Medicaid eligibility. All applicants that appear to be Medicaid eligible will be referred to DCF in the same manner as is done when enrollment is open. If not eligible for Medicaid, the family will be notified that they must re-apply or call to re-activate their application during the next open enrollment period. Once new enrollment can be processed, applications will be approved for coverage based on a first completed, first served basis, and based on available funding.

The number of children able to receive PIC services will be limited based on funding available at each of the pilot sites. It is estimated that approximately 15 children will be able to receive services at each site for an expected target enrollment of 150 Title XXI children. The goal of enrollment is to have 50 newly diagnosed children, 50 in the mid-stage of their life-threatening illness, and 50 at the end-of-their life. The total target enrollment in the pilot is 150 Title XXI children and an additional 150 Title XIX children.

☐ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))**

The Florida Healthy Kids Corporation or its third party administrator will perform Title XXI eligibility determinations for the Florida KidCare program except for Medicaid eligibility determinations. Applications for all children

who apply for one of the Florida KidCare components will be screened for potential Medicaid eligibility based on age, family size and income indicators (after applying income disregards), according to the most recent Federal Poverty Guidelines.

Applications for children who appear to be eligible for Medicaid will be referred to the Department of Children and Families for a full Medicaid eligibility determination.

During an open enrollment period, applications that indicate that a child has a special health care need are flagged for referral to the CMSN. In addition to being screened for possible Medicaid eligibility, CMSN staff will also screen the applications of children with special health care needs for participation in the CMSN. If a child has a special behavioral health care need, the CMSN review team will include representatives from the behavioral health network and/or the Department of Children and Families.

In the event the enrollment ceiling is reached and enrollment in the Title XXI programs ceases, children found ineligible for Title XIX will be returned to the FHKC and the family will receive a letter indicating that they are not eligible for Medicaid, that enrollment is currently closed for Title XXI coverage, and that they should re-apply or call KidCare Customer Service toll free (800) 821-5437, to re-activate their application during the next open enrollment period.

Effective July 1, 2012, Florida will allow the dependents of employees of a public agency who meet all eligibility requirements to enroll in subsidized CHIP coverage. This change is made in compliance with section 10203(d)(2)(D) of the patient Protection and Affordable Care Act which allows exceptions to the exclusion of children of employees of a public agency from enrolling in CHIP.

The condition is met through the maintenance of agency contribution criteria. The amount of expenditures the State made in in 2011 is not less than the amount of expenditures made by the State in 1997, adjusted for inflation. Each year going forward, an updated annual comparison will be calculated to determine if the maintenance of agency contribution has continued.

Appendix E contains the maintenance of agency contribution calculations chart which will be updated annually to ensure continued compliance with the maintenance of agency contribution requirement.

From July 1, 2012 through June 30, 2013, the 60-day crowd out waiting period will be suspended to allow for a transition from state employee coverage to CHIP coverage without a gap in coverage. Beginning July 1, 2013, normal crowd out policies will apply.

Appendix E contains the maintenance of agency contribution calculations chart which will be updated annually to ensure continued compliance with the maintenance of agency contribution requirement.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

All children who apply to the Florida KidCare program and who appear to be Title XIX eligible based on the Medicaid screening, will be referred to the Department of Children and Families for a full Medicaid eligibility determination. Those who are determined to be Medicaid-eligible will be enrolled in the Medicaid program.

As described in section 4.3, the State will provide provisional CHIP coverage for a child enrolled in CHIP and screened potentially eligible for Medicaid. The child will receive provisional CHIP eligibility from the month of the Medicaid referral through the month of the Medicaid eligibility determination. If the child is determined Medicaid eligible, provisional CHIP coverage will be terminated effective the following month. If the child is determined not Medicaid eligible, the child's CHIP coverage continues, provided the child meets all other factors of CHIP eligibility.

The Medicaid screening tool:

- Counts only the natural parent's income.
- Counts Social Security benefits.
- Disregards child support paid by parents as child support for children living outside of the home.
- Does not count stepparents in the filing unit.
- Does not count children's earned income, if in school.
- Deducts $90 for each member with earned income.

- Deducts a maximum of $200 childcare expense for children under 2, a maximum of $175 for children over 2.
- Deducts $50 if child support is received. (see Appendix A for a more detailed description of the Medicaid screening criteria).

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Children found ineligible for Title XIX will be processed for coverage in the appropriate Florida KidCare program component (MediKids, Healthy Kids, or the CMSN). If the application was received after the enrollment ceiling has been reached and applications for the Title XXI programs are not accepted, the family will be so advised and informed that they should re-apply or call to re-activate their application during the next open enrollment period.

Effective July, 1, 2009, the Department of Children and Families will transfer to FHKC, a nightly file of children who were denied or are no longer eligible for Medicaid due to being over income or aging out, to facilitate the transfer of children from Medicaid to Title XXI. The nightly file includes all of the data elements used by the Department of Children and Families to determine eligibility. A Title XXI eligibility determination will be made using the Medicaid data elements and other documentation as needed.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

All Title XXI Components

All applicants to the Florida KidCare program must be uninsured at the time of application and may not have voluntarily cancelled employer sponsored health insurance within the sixty days preceding their application for KidCare coverage, unless the cancellation reason meets one of the exemptions to the 60 day policy included in section 4.1.7. An annual evaluation of the Florida KidCare program is also conducted which questions new enrollees about their

health insurance status prior to enrollment in Florida KidCare.

Florida KidCare Program

The University of Florida, Institute for Child Health Policy, under contract with the Agency for Health Care Administration, conducts annual evaluations of the Florida KidCare program. This evaluation also queries the parents of new enrollees as to their child's insurance status prior to enrollment in the Florida KidCare program.

Healthy Kids

The Florida Healthy Kids Corporation, as with all other KidCare program components other than Medicaid, requires children to be uninsured at the time of application to the program. This, coupled with open enrollment periods, contributes to FHKC's findings about crowd out. Recent studies of the insurance status of children prior to enrolling in Healthy Kids show that over 90% of participants were uninsured in excess of 12 months before seeking coverage through the Healthy Kids program. Of the 10% who had insurance at one point within the year prior to enrolling in Healthy Kids, only 13% had employer-based private health insurance.

Of the parents whose children are enrolled in Healthy Kids, 86% are employed, 38% of whom are employed part-time. Most of these parents work in blue collar and service industry positions. For example, 9% of the reported jobs are in construction, 6% are cleaning and janitorial, and 6% are food service. Another 9% of the total reported jobs are in the category of self-employed.

Healthy Kids serves as a bridge between public sector and private health insurance coverage. Of the children who disenrolled from Healthy Kids, 48% obtained other insurance coverage. Of those that obtained other coverage, the majority moved to employer-based coverage with the next largest group reporting that they enrolled in the Medicaid program. All of these findings support the continuation of the requirement that children be uninsured at the time of application.

In addition, the State of Florida conducted a study assessing crowd out in the Florida Healthy Kids program utilizing the same methodologies used in the study dated January 15, 1998, and reported the findings to the Centers for

Medicare and Medicaid Services within 6 months of implementation.

Children's Medical Services Network

A child must be uninsured at the time of application for enrollment in the CMSN and the child must meet the clinical and financial Title XXI eligibility criteria for the CMSN. In addition to meeting other Title XXI eligibility requirements, a child must also meet clinical eligibility requirements to qualify for the CMSN.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Florida has two federally recognized Native American Tribes: The Seminole Tribe and the Miccosukee Tribe. Native Americans represent less than 1% (0.28%) of Florida's population of 14.9 million in 1998. Approximately 9,200 Native American children reside in Florida (*1997 Kids Count: Profiles of Child Well-Being*, Annie E. Casey Foundation). Native American children under age 19 represent less than one-half of one percent of the approximately

715,000 children enrolled in Medicaid (about 349 children under age 19 enrolled in Medicaid are Native Americans).

Applications are sent to the two Native American Tribes for distribution. In addition, the KidCare application effective January 2003, asks a question regarding applicant race. If the family indicates the applicant is an Alaskan Native or American Indian, the family is sent a letter advising the family that if they are interested in receiving full premium subsidy and no co-payments, they can provide tribal membership documentation.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program:
(Section 2102(c)(1)) (42CFR 457.90)

In a special session in May 2003, the Florida Legislature eliminated funding for Florida KidCare's outreach program effective July 1, 2003, and the 2004 Legislature eliminated the Department of Health's formal outreach duties from the Florida KidCare Act. The Department of Health's KidCare outreach program transferred some of its activities to the Children's Medical Services Network located within the Department, and some activities were continued by other Florida KidCare partner agencies: the Agency for Health Care Administration, the Department of Children and Families, and the Florida Healthy Kids Corporation.

Action by the 2004 Legislature eliminated references in the Florida KidCare Act to the identification of low-income, uninsured children and most other references to outreach. State funding was not restored for this purpose.

The 2005 Legislature allocated up to $40,000 in state funds for the distribution of Florida KidCare program information to school-aged children on the first day of the 2005-2006 school year. The statewide distribution of more than 2.2 million postcards is planned for early August when most Florida schools return for the new school year.

The 2006 and 2007 Legislature allocated $1,000,000 in non-recurring state funds (no Federal matching funds will be used) for a KidCare community-based marketing and outreach matching grant program. Florida Healthy Kids Corporation will administer the program and award grants based on proposals submitted by community organizations. The grants are intended to promote new and innovative approaches to reach uninsured children with the goal of increasing enrollment. Special attention will be given to the following groups identified by Florida Healthy Kids Corporation as underserved.

- African-Americans
- Children ages 5 – 8
- Children of self-employed parents

- Uninsured children in the Panhandle and Tampa Bay regions

In 2007, the Governor's Office convened the Florida KidCare Outreach Task Force, made up of representatives from the KidCare partner agencies, plus the University of South Florida's Covering Kids and Families, the Agency for Work Force Innovation, Department of Education and Volunteer Florida. The goal of the Task Force has been to encourage outreach activities and coordinate outreach activities throughout the state. The Florida KidCare Outreach Task Force continues to meet regularly and strategize on effective outreach campaigns.

A Multi-Media Marketing Campaign

Florida took the first step by integrating its child health insurance programs under a single new name in July 1998: The Florida KidCare program. The Department of Health initiated a major statewide outreach effort to inform families of available health insurance benefits for uninsured children during the first year of the program, 1998. In subsequent years, annual multimedia campaigns have continued, with the bulk of the effort taking place during the fall as children return to school.

In 2003, due to the elimination of funding for outreach and the enrollment limits for the KidCare program, no statewide media campaigns will be initiated.

Since 2003, despite limited funding since 2003, the Florida KidCare partners have continued to identify other methods for conducting marketing and outreach activities for the Florida KidCare program. In state fiscal years 2007-08 and 2008-09, $1,000,000 in state funds was appropriated for a Florida KidCare community-based marketing and outreach matching grant program to be administered by the Florida Healthy Kids Corporation. Additionally, the Corporation initiated a "Boots on the Ground" effort that focused on community based projects and hands-on application assistance and provided outreach materials, training and technical support.

Since 2007, the Agency for Health Care Administration has contracted with the University of South Florida's Covering Kids and Families to develop outreach coalitions in target areas of the state and to build business partnerships to promote Florida KidCare. Florida Healthy Kids Corporation also contracts with Covering Kids and Families to work with the "Boots on the Ground" organizations and school outreach efforts. The Department of Health, working through the county health departments, engaged in many outreach activities and provided outreach materials.

Single Application

In 1998 Florida modified the existing Florida Healthy Kids application to become the

official Florida KidCare/Healthy Kids application for Title XXI and Title XIX for children. In subsequent years, this application has undergone several revisions in order to create a family friendly and user-friendly process. The application was revised again in early 2003 to capture racial and ethnic data and to add other new elements, such as new questions for screening children who may be eligible for the Children's Medical Services Network (CMS). The application has been revised in 2004 and 2005 to include documentation requirements, access to employer-sponsored insurance information, and the 120 day limit on the application process. The application was again revised in 2009 to incorporate policy changes and to make the application more informative and user-friendly.

Families also continue to have the option of applying for children's health benefits only on the Florida KidCare application or for applying for cash assistance and Medicaid on the "Request for Assistance" form, or through the Department of Children and Families' on-line Access application. State law specified the development of a simplified application process. Families using the Florida KidCare application mail their applications to the Florida Healthy Kids Corporation for processing by the TPA.

Applications are available at a variety of locations year round or by calling the Florida KidCare toll-free hotline at 1-888-540-5437. Additionally, applications can be downloaded from either the Florida KidCare web page or the Healthy Kids web page as described below. Beginning February 2006, an online KidCare application was available through the Healthy Kids website. There are links to the online application from the Florida KidCare website and from the Department of Children and Families' online application website.

Effective June 10, 2005, applications for the Florida KidCare Program will be accepted year-round for the purpose of enrolling children eligible for all Title XXI program components. Children will be enrolled on a first-completed, first-served basis using the date the application is received. Enrollment shall cease when the enrollment ceiling is reached. Enrollment may resume when the Social Services Estimating Conference determines sufficient federal and state funds are available to finance the increased enrollment through federal fiscal year 2007.

KidCare Information Line

The Florida Department of Health transitioned its toll-free telephone line (1- 888-540-KIDS) to the Agency for Health Care Administration effective July 1, 2003, so that families can continue to receive assistance with obtaining applications and answers to questions about the Florida KidCare program. Effective July 1, 2004, the function of

the toll-free information line was transferred to FHKC. The toll-free number is published in all Florida KidCare printed materials. Marketing materials remaining from the Department of Health are available to all community organizations for a nominal shipping charge, as supplies last.

The Florida Healthy Kids Corporation has contracted this service out to a call center vendor and calls are answered Monday through Friday from 8:00 a.m. to 6:00 p.m. (eastern).

In addition to the KidCare Information Line for general KidCare information and applications, applicants and active families may obtain account status information from KidCare Customer Service at 800-821-5437. All phone lines offer callers the ability to communicate in multiple languages.

WWW.FLORIDAKIDCARE.ORG Website and www.healthykids.org

Florida's outreach strategies include the creation of a KidCare website to provide an overview of the program, answers to frequently asked questions, links to related sites, and an on-line application for downloading and completion. All printed KidCare materials include the website address.

The Florida Healthy Kids Corporation also has its own web site, which includes information about what health and dental plans are available in each county, the cost of the program, the benefits, as well as links to other useful sites.

The Healthy Kids website has recently been updated and re-focused in order to meet the changing needs of its enrollees. Scheduled for a July 2006 launch, the Healthy Kids website will include access to limited account information for current enrollees. The site is secure and will require the use of passwords and PINs to protect the privacy of its members. Later phases of the website redesign will include more information and access for applicants to the program. Beginning February 2006, an online KidCare application was available through the Healthy Kids website. There are links to the online application from the Florida KidCare website and from the Department of Children and Families' online application website. The on-line application is available in English, Spanish and Creole. Families use an electronic signature when submitting an on-line application.

KidCare Coordinating Council

The KidCare Coordinating Council was created in statute as the advisory council for the Florida KidCare program and is composed of key agency and industry representatives, stakeholders and advocates that meet quarterly to receive updates

from all KidCare program components and make recommendations to the Legislature and Governor for improvement of the KidCare program. Effective July 1, 2003, the KidCare Coordinating Council is staffed by the Department of Health's Children's Medical Services Program.

Past Covering Kids and Families (FL CKF) Outreach Activities

Previously funded RWJ local projects included the Health District of Palm Beach County, whose activities this year have been to conduct outreach to special populations by working with Haitian and Hispanic families through community partner organizations that reach out to those families. They have Creole and Spanish speaking representatives available at the customer service local toll-free number. The projects work closely with the Hispanic Chamber of Commerce and have made presentations to families at ESOL parent meetings. In addition, they have distributed KidCare program information to Hispanic and Haitian parents at Kindergarten Round-ups (registration). Other activities include working with small businesses, temporary employment agencies, H&R Block, WIC and WIC recipients, OPS employees, and participating at community events. The projects initiated a modest KidCare media campaign in May 2003, participated in Back-to-School events, and worked with Law Enforcement and Law Enforcement Explorers, both local and statewide. They developed and distributed a screensaver, held a New Application Forum; worked with School District of PBC regarding Free and Reduced meal application; maintained a Health Care District website with updated Florida KidCare information and links; trained community partners; and created a program navigating guide for enrolled families.

The Panhandle Area Health Network local project's major highlights are training African American pastors on the importance of KidCare and partnering with them at community events. In addition, they train and partner with the migrant community liaison to promote KidCare and its value to the migrant community.

The Northeast Florida Healthy Start Local Project's activities include:

- Opened the Healthy Homes Information Center (for parents) at Woodland Acres Elementary;
- Conducted 13 community education programs in targeted neighborhoods;
- Conducted the Woodland Acres Fall Festival with 777 participants;
- Conducted the Woodland Acres Medicaid forum including representatives from DCF, AHCA, and Department of Financial

Services, and served a total of 39 participants; and
- Distributed 8500 Project Healthy Homes information pieces and 12,500 applications in non-school organizations.

The Miami-Dade local project at Jackson Memorial Hospital has made an extensive effort with H&R Block and Jackson Hewitt (tax preparers) during which they provided hundreds of applications and KidCare materials to these organizations for their clients. In addition, since January, they have been working with local DCF offices and WIC to provide materials and supply them with Florida KidCare items during health fairs. They have worked with several head start and day care centers promoting dental hygiene and giving away toothbrushes. Their office was represented at the Prosperity Campaign sponsored by Human Services Coalition and the Department of Labor to empower women to be financially independent. They assisted with presenting a workshop that provided information on job applications. Their populations are predominantly African Americans, Hispanics, and Haitians. They have participated in press conferences and work closely with DCF to reach targeted populations.

All funding from the Robert Wood Johnson Foundation for the local projects ended on March 31, 2006.

Current Covering Kids and Families Outreach Activities

FL CKF, a funded project of the University of South Florida's College of Public Health, focuses on informing families about the Florida KidCare program. Using the latest data to improve outcomes, CKF collaborates on increasing effective communication, especially with minority and special populations and those people who influence them (e.g., providers, friends, and extended family members). The project has been distributing materials in Spanish, English and Creole to community partners across the state. The state grantee has also been working with the Florida State Hispanic Chamber of Commerce, Florida Hospitals, utility companies, pharmacies, cable companies, and others to let potentially eligible families know about Florida KidCare. FL CKF uses a collaborative model – the coalition- to achieve its goals. The Florida Covering Kids and Families Coalition is a key element of the CKF Project. The Coalition is composed of state agency representatives, child advocates, community health care providers, health plans, parents, Haitian community-based organizations, Florida Farm Workers Association, local community projects, and business leaders. CKF, through the Coalition, has been working with state and regional groups and other hard-to-reach populations. The Coalition works with local

coalitions to test strategies for renewal and retention, reduce barriers due to language and cultural differences, stigma and distrust associated with public programs and government staff, fear of deportation, low literacy, and transient populations.

The goal is to build a strong ongoing outreach and enrollment program that is family-friendly, easy to access, and coordinated with other insurance alternatives. The Coalition also shares its recommendations with the Florida KidCare Coordinating Council. CKF has assisted with simplifying the letters sent to families from the Healthy Kids Corporation to families through the proper literacy levels and easy to read language. CKF also works with the agencies when changes to the application are necessary. In addition, in the absence of a state funded outreach program, CFK has supported and provided all statewide coordinated outreach efforts through technical assistance and other support since July 2003.

Currently the Covering Kids Coalition is focusing on expanding and diversifying its representation in order to focus on achieving the goals of Covering Kids and Families. The three goals are: coordination, simplification, and outreach. The coalition is striving to reach its goals in order obtain sustainability in outreach and increase enrollment and retention in Florida KidCare. One way to move towards achieving the goals is to focus on issues and changes in the program via sub-committees or workgroups. The five ad-hoc sub-committees are: rural health, business and workforce, community partnerships, process improvement, and special populations. The sub-committees evaluate the issues that relate to each of the workgroup's area and make recommendations to the Coalition as to how to address those issues and the next steps that need to be taken.

Since 2007, the Agency for Health Care Administration has contracted with the University of South Florida's Covering Kids and Families (CKF) to develop outreach coalitions in target areas of the state and to build business partnerships to promote Florida KidCare. The Florida Healthy Kids Corporation also contracts with CKF to work with the local "Boots on the Ground" organizations, provide technical assistance and to develop partnerships within designated districts.

Provider and Community Participation

The initial outreach effort was implemented at the local level to reach potentially eligible families by training providers of services to low-income children to conduct outreach, distribute applications, and assist families with completing the application form and renewal process. CKF continues to support these activities by providing training and technical assistance. Community partners in this initial effort included:

Schools

Schools have a long-standing partnership the KidCare program. Applications are often sent home with children in those participating school districts at the beginning of the school year. School nurses and school social workers are an integral part of outreach in the school systems.

County Health Departments & Community Health Centers

County health departments (CHDs) and community health centers (CHCs), which include programs such as WIC and have served as a health safety net for low-income families, see many families who may be potentially eligible for Medicaid or Title XXI.

CHD and CHC staffs were trained to help families apply for the Florida KidCare program. CHDs play a pivotal role in outreach as a core public health activity. CHDs will serve as the community hub; working with a consortium of local agencies to assure that there is a coordinated and accountable outreach effort.

The CHDs are in a unique position to reach out to adolescent and teen populations. The CHDs conduct presumptive eligibility for pregnant women and teens and have a history of reaching out to underserved groups. In addition, through school health programs, the CHDs can identify school-age children and adolescents who may qualify for the Florida KidCare program.

Healthy Start Coalitions

Florida's Healthy Start Coalitions form a statewide mechanism for local planning to prevent poor maternal and child health outcomes for pregnant women and children from birth to age 3.

Coalitions will distribute brochures on child health insurance eligibility for providers and coordinate their local outreach efforts with the public and

	private sectors, CMSN, childcare, Head Start, WIC and pre-kindergarten programs. Composed of representatives of all major maternal and child health providers, business representatives, and advocates, the coalitions have a built-in system for outreach; particularly among women and infants whose Healthy Start risk screening scores identify them as at-risk. In addition, there is a Family Health hotline with a toll-free number which can be used for outreach and immediate access needs.
Child Care Providers & Early Education Programs	Education programs such as Head Start and other subsidized child care organizations have application processes that allow them to gather information that may be used to evaluate potential eligibility. They are in a position to alert agencies about eligible uninsured children and to provide Florida KidCare applications and valuable insurance information to families.
Department of Children & Families	The service centers provide Florida KidCare applications and information about the Title XXI program to families whose uninsured children are ineligible for Medicaid.
Hospitals	Hospitals have formed a partnership with the Department of Health to help utilize emergency rooms and newborn intensive care units for the dissemination of Florida KidCare applications and information about health insurance for children.
Provider Training Programs	Other key providers will be trained at the local level on the application process and taught how to assist families in enrolling in KidCare. Training is also provided to medical students, providers of mobile units and nurses.

Outreach to Special Populations

Florida will target the following special populations for intensive outreach efforts:

- Minority Populations

A coalition has been established to address the unique needs of Florida's minority populations. This group consists of representatives from the Native American community, Hispanics, African-Americans, and other minority groups.

Recommendations from this group will be used by the Florida KidCare Coordinating Council for policy development for minority child populations.

Representatives from the Native American community are involved in the special populations outreach task force and they help provide input. The task force will provide feedback to the state and local offices for changes that need to be made to increase minority enrollment, including Native American children's enrollment, in the Florida KidCare program.

The Florida Covering Kids and Families Project will continue to produce and disseminate print information in Spanish, English and Creole and distribute television and radio PSAs in Spanish and English. The project will have a coordinated Back-to-School effort during open enrollment periods and will continue to provide necessary technical assistance to local communities as needed.

The Florida Healthy Kids Corporation (FHKC) also has significant experience with Hispanic populations in Florida. FHKC has found that families of Hispanic children rely on word-of-mouth, Hispanic newspapers and Hispanic radio and television stations as primary information sources for learning about child health insurance.

Community organizations focusing on the Haitian communities are engaged in outreach activities by reviewing outreach materials, providing translations, participating in radio shows, organizing outreach church activities and other outreach activities aimed at the Haitian population.

- Children With Special Health Care Needs

The CMSN oversees outreach for children with special health care needs. Examples of participants in this effort will include:

  - Hospitals and health care providers. Regional Perinatal Intensive Care Centers employ individuals who refer sick newborns to CMSN for on-going care.
  - "Child Find" through the Department of Education for infants and toddlers who qualify for the Early Intervention Program.

- The Vocational Rehabilitation Division of the Department of Education refers children under the age of 17 with brain and spinal cord injuries to CMSN.
- The Social Security Administration for all SSI child beneficiaries under the age of 17. CMSN in turn coordinates care or transmits the referral to an appropriate agency.
- County health departments and community health centers. CHDs and CHCs make referrals for infants and children assessed as needing special health care. In many areas—especially rural counties—county health departments provide space for special CMSN clinics, thus improving access to care.
- Medicaid offices and choice counselors refer children to the CMSN. CMSN is included in the Medicaid materials as a Medicaid managed care option for Medicaid child beneficiaries with special health care needs.
- Family advocacy groups that work with CMSN, and the CMSN clinics, which can be accessed by every region in Florida.
- Florida Healthy Kids Corporation health plans, based on utilization and diagnostic information.
- Local school districts.

Additional outreach to school-age children with serious emotional disturbance includes:

- Agencies under contract with the Department of Children and Families for mental health or substance abuse treatment services;
- The Florida Diagnostic and Learning Resources Systems (FDLRS), which are regional networks funded by the state Department of Education that provide support to school districts and families for assessments and educational planning for handicapped students; and
- Regional Multi-agency Service Networks for Children with Severe Emotional Disturbance (SED Networks).

Healthy Kids

Healthy Kids will also continue its public information efforts, which focus on school-age children. Healthy Kids has, in the past, entered into contractual arrangements with

school districts in order to facilitate the distribution of applications annually.

FHKC does not use commissioned insurance agents for marketing and enrollment. One of the primary objectives of any marketing strategy utilized by Healthy Kids is to keep the materials simple to understand. Materials are available in multiple languages, based on the specific needs of a county. FHKC's TPA employs a multi-lingual staff and has access to other translation services in order to assist families calling on its toll-free lines.

Healthy Kids has previously developed "Marketing Tool Kits" for community based organizations. First introduced during the January 2005 open enrollment, these tool kits provided organizations with pre-approved marketing materials for open enrollment activities and were very popular. With the return to year-round open enrollment, a new tool kit is being developed for distribution in late Summer 2005. The tool kit includes print-ready copies of flyers, brochures, posters, tension banners, radio and television ads. Community based organization then can utilize their own resources to fund distribution and the KidCare program can feel comfortable that the information being disseminated is accurate and appropriate for the population. The tool kits have been updated as needed.

Section 6. Coverage Requirements for Children's Health Insurance

☐ 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 proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42 CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in

Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR

457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☒ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified,

provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Healthy Kids Benefits Package was grandfathered in.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☒ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. ☒ Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).

Benefits for the MediKids program and for the Children's Medical Services Managed Care Plan (CMS Plan)are the same as for Medicaid,

which includes EPSDT.

The Healthy Kids program does not provide EPSDT benefits.

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver.

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population.

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than coverage under one of the benchmark plans specified in 457.420, through the use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done).

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other. (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42 CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR 457.490)

MediKids, CMS Plan (including children enrolled through the CMS Plan Enrollment Exception Process), Florida Healthy Kids

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

6.2.3. ☒ Physician services (Section 2110(a)(3))

6.2.4. ☒ Surgical services (Section 2110(a)(4))

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

Healthy Kids: Covers all prescriptions in the same manner in which the Florida Medicaid program provides. Participant is limited to the generic drug unless a generic is

not available, or the prescriber indicates that the brand name is medically necessary

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.11. ☒ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.12. ☒ Home and community-based health care services (Section 2110(a)(14))

Healthy Kids: Home health services are limited to skilled nursing services only. The benefit is intended to provide services on a limited, part-time intermittent basis and excludes meals, housekeeping and personal comfort items.

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.13. ☒ Nursing care services (Section 2110(a)(15))

Healthy Kids: Nursing services in Healthy Kids are limited to skilled nursing only.

6.2.14. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.15. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Children enrolled in MediKids and the CMS Plan receive Medicaid dental benefits from Medicaid-enrolled providers.

Healthy Kids: Healthy Kids enrollees also receive the Medicaid dental benefit package.

See Section 6.2.-D

Effective July 1, 2010, Healthy Kids dental benefits are provided statewide by two (2) commercially licensed dental insurers. The annual dental benefit limit was eliminated to comply with CHIPRA legislation. If a child needs oral surgery due to an accident or injury to the mouth or jaw, this coverage would still be provided under the child's medical services contractor and not the dental contractor**.**

6.2.16. ☒ Vision screenings and services (Section 2110(a)(24))

6.2.17. ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.18. ☐ Case management services (Section 2110(a)(20))

6.2.19. ☒ Care coordination services (Section 2110(a)(21))

Care coordination services is limited to CMS Plan Title XXI enrolled children.

6.2.20. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Healthy Kids: Therapy services are limited to 24 treatment sessions within 60-day period and are intended for short-term rehabilitation only.

6.2.21. ☒ Hospice care (Section 2110(a)(23))

Healthy Kids: Once a family elects hospice care for an enrollee, other services that treat that terminal condition will not be covered.

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.22. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

The provision of EPSDT benefits only applies to MediKids and CMS Plan. The Healthy Kids program does not provide EPSDT benefits.

6.2.22.1 ☒ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Florida's separate Children's Health Insurance Program provides behavioral health and substance abuse services to children ages one through eighteen years. The CHIP enrollees receive an array of age-appropriate behavioral health services through Florida Healthy Kids, the Behavioral Health Network (BNet), MediKids, and Children's Medical Services (CMS) Health Plan.

Healthy Kids: The Florida KidCare Act, outlines the benchmark health care benefits Florida Healthy Kids must include as medically necessary. The Florida Healthy Kids program serving children ages 5 to 19 does not provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Behavioral health and substance use disorder services in excess of those specified in the Florida KidCare Act may be obtained through the Behavioral Health Network (BNet) via CMS Health Plan enrollment. Florida Healthy Kids refers children and families in need of behavioral health and substance use disorder services to CMS Health Plan for clinical assessment.

MediKids: Children ages 1 through 4 eligible for CHIP services are enrolled in MediKids and receive EPSDT services. The program enrollees receive behavioral health services through Florida Medicaid's Managed Medical

Assistance (MMA) Program health plans. MediKids enrollees are also age appropriate for medically necessary early intervention services provided through the Healthy Start and Early Steps programs.

Children's Medical Services Health Plan: The CMS Health Plan is a KidCare Title XXI program serving children and adolescents ages 1 through 18 years with special health care needs. Children enrolled in the CMS Health Plan are eligible for EPSDT services and are clinically eligible to receive medically necessary behavioral and developmental health services.

BNet is a statewide network of behavioral health service providers serving children ages 5 to 19 years of age with serious emotional disturbance, serious mental health disorder, or substance use disorders, eligible for the Florida KidCare Title XXI program and enrolled in the CMS Health Plan. A child enrolled in BNet receives medical health services from the CMS Health Plan, behavioral health services, and related medication through BNet.

BNet providers address enrollee's behavioral health needs through:

- In-home and outpatient individual and family counseling.
- In-home and outpatient targeted case management.
- Psychiatry services and medication management including direct access to the network service provider's pharmacy with no co-pays; and
- Advocacy and provision for wrap-around services to meet each child's social, educational, nutritional, and physical activity needs.

Pregnant Women: Florida has not elected to cover pregnant women under the CHIP option offered in section 2112 of the Social Security Act. Medically necessary mental health and substance use disorders services are offered to pregnant women through the Florida Medicaid (Title XIX) program.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local

government or is licensed under State law and operating within the scope of the license.

6.2.23. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.24. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.25. ☒ Medical transportation (Section 2110(a)(26))

Healthy Kids covers emergency medical transportation only.

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.26. ☐ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.27. ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

For Children's Medical Services network only, additional benefits for early intervention services, respite services, genetic testing, genetic and nutritional counseling, and parent support services may be offered, if such services are determined to be medically necessary.

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:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
  - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
  - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
  - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally

and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

- ☐ State-developed schedule
- ☒ American Academy of Pediatrics/ Bright Futures
- ☐ Other Nationally recognized periodicity schedule (please specify:)
- ☐ Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

Children enrolled in the Children's Medical Services Health Plan are eligible for EPSDT services and are clinically eligible to receive medically necessary behavioral and developmental health services. MediKids enrollees receive behavioral health services through Florida Medicaid's Managed Medical Assistance (MMA) Program providers. MediKids enrollees are also age appropriate for medically necessary early intervention services provided through the Healthy Start and Early Steps programs. The BNet program is available to children enrolled in the Children's Medical Services Health Plan, ages 5 through 18 who have mental health or substance use concerns. The BNet program is also available to children enrolled in the Title XXI Florida Healthy Kids program. If found clinically eligible for the CMS Health Plan program, the child is disenrolled from the Florida Healthy Kids Program as they can not be dually enrolled in both programs.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral

health screenings and assessments described in the assurance below at 6.3.1.1-BH.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

The amount, scope and duration of Florida Healthy Kids behavioral health screenings and assessment services, including substance use disorder evaluations, are provided as determined medically necessary.

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

Beginning in 2021, Florida Healthy Kids requires its managed care organizations (MCOs) to report the child core set measure, CDF-CH, "screening for depression and follow-up plan: ages 12-17". Florida Healthy Kids requires the MCOs to implement performance improvement projects to improve the rate of enrollees who have been screened for depression using a standardized tool and who had a documented follow-up plan for those enrollees with a positive screening. In addition, the Florida Healthy Kids Corporation (FHKC) requires the MCOs to make information about using age-appropriate, validated behavioral health screening tools available to providers on their provider-facing websites, provider manuals, and provider toolkits. The MCOs review and update websites, provider manuals, and provider toolkits annually or as needed. Providers are educated on where the tools are located during onboarding as a new network provider and as part of ad hoc/on-demand provider training.

The Agency for Health Care Administration and the University of South Florida collaborate to disseminate updates regarding behavioral health policy to Florida Medicaid health plans and medical providers in the form of Florida Medicaid Policy Transmittals and Policy Alerts as necessary through the Florida Behavioral Health Center website, which is updated every two weeks.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The amount, scope and duration of psychosocial treatment services provided by MediKids, Florida Healthy Kids, and CMS Health Plan, including outpatient treatment and counseling services for behavioral health and substance use disorder conditions, are provided as determined medically necessary.

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

The amount, scope and duration of tobacco cessation services provided by MediKids, Florida Healthy Kids, and CMS Health Plan, including therapy/counseling services and drugs prescribed for the purpose of tobacco cessation, are provided as determined medically necessary. Medically necessary services are rendered to recipients in lieu of service limits.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

The State covers all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

The amount, scope and duration of Florida Healthy Kids Medication Assisted Treatment services, including inpatient and outpatient services for psychological or psychiatric evaluation, diagnosis, and treatment, are provided as determined medically necessary. This applies to all subsections of 6.3.2.3.

6.3.2.3.1- BH ☒ Opioid Use Disorder

6.3.2.3.2- BH ☒ Alcohol Use Disorder

6.3.2.3.3- BH ☒ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Florida Healthy Kids does not provide Peer Support Services as a covered benefit. Medically necessary Peer Support Services unavailable through Florida Healthy Kids coverage may be obtained through the BNet program.

6.3.2.5- BH ☒ Caregiver Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Florida Healthy Kids does not provide Caregiver Support Services as a covered benefit. Medically necessary Caregiver Support Services unavailable through Florida Healthy Kids coverage may be obtained through the BNet program.

6.3.2.6- BH ☒ Respite Care
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Florida Healthy Kids does not provide respite care services as a covered benefit. Respite care services unavailable through Florida Healthy Kids coverage may be

obtained through the BNet program.

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Florida Healthy Kids does not provide intensive in-home services as a covered benefit. Intensive in-home services unavailable through Florida Healthy Kids coverage may be obtained through the BNet program.

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The amount, scope and duration of Florida Healthy Kids intensive outpatient services are provided as determined medically necessary.

The State defines intensive outpatient services as "outpatient" in Ch. 65E 14.021(4), F.A.C for BNet Services. The definition can be found below.

"Outpatient:
Outpatient services provide a therapeutic environment, which is designed to improve the functioning or prevent further deterioration of persons with mental health and/or substance abuse problems. These services are usually provided on a regularly scheduled basis by appointment, with arrangements made for non-scheduled visits during times of increased stress or crisis. Outpatient services may be provided to an individual or in a group setting. The group size limitations applicable to the Medicaid program shall apply to all Outpatient services provided by a SAMH-Funded Entity. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service."

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Florida Healthy Kids does not provide psychosocial rehabilitation services as a covered benefit.
Psychosocial rehabilitation services unavailable through Florida Healthy Kids coverage may be obtained through the Title XXI CMS Health Plan or the BNet program.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The State defines day treatment and partial hospitalization to be the same benefit. See description provided in subsection 6.3.3.1 - BH.

Florida Healthy Kids does not cover day treatment services that are outside regular outpatient services. Title XXI CMS Health Plan or the BNet provides medically necessary day treatment services.

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The State defines "partial hospitalization" as "Day Treatment" in Ch. 65E 12.021(4), F.A.C. The definition can be found below.

"Day Treatment:
Day treatment services provide a structured schedule of non-residential services for four (4) or more consecutive hours per day. Activities for children and adult mental health programs are designed to assist individuals to attain skills and behaviors needed to function successfully in living, learning, work, and social environments. Activities for substance abuse programs emphasize rehabilitation, treatment, and education services, using multidisciplinary teams to provide integrated programs of academic therapeutic, and family services."

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))
Provided for: ☒ Mental Health ☒ Substance Use Disorder

A child who is an inmate of a public institution or patient in an institution for mental diseases is not eligible for the Florida KidCare program.

Florida Healthy Kids covers inpatient and residential treatment services for behavioral health and substance use disorder conditions.

BNet provides a limited number of days of medically necessary mental health and substance use crisis stabilization, inpatient and outpatient hospital services, and residential services. A child assessed as needing more than 30 days residential mental health or seven days residential substance use treatment is not clinically eligible for the BNet program. The BNet provider responsibility for inpatient is limited to 10 days per year for mental health, seven days for substance use, and the first 30 days of residential care, after which payment responsibility shifts back to the CMS Health Plan.

Children enrolled in either MediKids or Title XXI CMS Health Plan receive medical services and benefits from Medicaid providers. Program age-appropriate recipients under age 21 requiring medically necessary Statewide Inpatient Psychiatric Program (SIPP) can receive treatment in a psychiatric residential setting due to a primary diagnosis of emotional disturbance or serious emotional disturbance. SIPP services provide extended psychiatric residential treatment with the goal of facilitating successful return to treatment in a community-based setting. SIPP services include individual plan of care, assessment, routine medical and dental care, certified educational programming, recreational, vocational, therapeutic group and behavior analysis services and therapeutic home assignment.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☒ Residential Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The amount, scope and duration of Florida Healthy Kids residential treatment services are provided as determined medically necessary.

The State defines "Residential treatment" in Ch. 65E 12.021(4), F.A.C. The definition can be found below.

"Residential Level I.
These licensed services provide a structured, live-in, non-hospital setting with supervision on a twenty-four hours per day, seven days per week basis. A nurse is on duty in these facilities at all times. For adult mental health, these services include group homes. Group homes are for longer-term residents. These facilities offer nursing supervision provided by, at a minimum, licensed practical nurses on a twenty-four hours per day, seven days per week basis. For children with serious emotional disturbances, Level 1 services are the most intensive and restrictive level of residential therapeutic intervention provided in a non-hospital or non-crisis support unit setting, including residential treatment centers. Medicaid Residential Treatment Centers and Residential Treatment Centers are reported under this Covered Service. On-call medical care shall be available for substance abuse programs. Level 1 provides a range of assessment, treatment, rehabilitation, and ancillary services in an intensive therapeutic environment, with an emphasis on treatment, and may include formal school and adult education programs.

Residential Level II.
These facilities are licensed, structured rehabilitation-oriented group facilities that have twenty-four hours per day, seven days per week, supervision. Level II facilities house persons who have significant deficits in independent living skills and need extensive support and supervision. For children with serious emotional disturbances, Level II services are programs specifically designed for the purpose of providing intensive therapeutic behavioral and treatment interventions. Therapeutic Group Home, Specialized Therapeutic Foster Home – Level II, and Therapeutic Foster Home – Level 2 are reported under this Covered Service. For substance abuse, Level II services provide a range of assessment, treatment, rehabilitation, and ancillary services in a less intensive therapeutic environment with an emphasis on rehabilitation and may include formal school and adult educational programs.

Residential Level III.
These licensed facilities provide twenty-four hours per day, seven days per week supervised residential alternatives to persons who have developed a moderate functional capacity for independent living. For children with serious emotional disturbances, Level III services are specifically designed to provide sparse therapeutic behavioral and treatment interventions. Therapeutic Group Home, Specialized Therapeutic Foster Home – Level I, and Therapeutic Foster Home – Level 1 are reported under this Covered Service. For adults with serious mental illness, this Covered Service consists of

supervised apartments. For substance abuse, Level III provides a range of assessment, rehabilitation, treatment and ancillary services on a long-term, continuing care basis where, depending upon the characteristics of the individuals served, the emphasis is on rehabilitation or treatment.

Residential Level IV.
This type of facility may have less than twenty-four hours per day, seven days per week on-premises supervision. It is primarily a support service and, as such, treatment services are not included in this Covered Service, although such treatment services may be provided as needed through other Covered Services. Level IV includes satellite apartments, satellite group homes, and therapeutic foster homes. For children with serious emotional disturbances, Level IV services are the least intensive and restrictive level of residential care provided in group or foster home settings, therapeutic foster homes, and group care. Regular therapeutic foster care can be provided either through Residential Level IV "Day of Care: Therapeutic Foster Home" or by billing in-home/non-provider setting for a child in a foster home."

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

The amount, scope and duration of Florida Healthy Kids detoxification services are provided as determined medically necessary.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility-based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The amount, scope and duration of Florida Healthy Kids emergency services are provided as determined medically necessary.

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The amount, scope and duration of Florida Healthy Kids crisis intervention and stabilization services are provided as determined medically necessary.

The State distinguishes Crisis Stabilization from Crisis Support/Emergency services in Ch. 65E-14.021(4), F.A.C. The definitions can be found below.

"Crisis Stabilization.
These acute care services offered twenty-four hours per day, seven days per week, provide brief, intensive mental health residential treatment services. These services meet the needs of individuals who are experiencing an acute crisis and who, in the absence of a suitable alternative, would require hospitalization."

"Crisis Support/Emergency.
This non-residential care is generally available twenty-four hours per day, seven days per week, or some other specific time period, to intervene in a crisis or provide emergency care. Examples include mobile crisis, crisis support, crisis/emergency screening, crisis telephone, and emergency walk-in."

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Florida Healthy Kids does not cover care coordination services. Medically necessary Mental Health and Substance Use Disorder Care Coordination unavailable through Florida Healthy Kids coverage may be obtained through the BNet program.

CMS Health Plan and MediKids define Care Coordination in conjunction with the delivery of Case Management. The goal of this service is to assess, plan, implement, coordinate, monitor, and evaluate the options and services required to meet health needs using communication and all available resources to promote quality outcomes.

In accordance with section 394.4573(1)(a), F.S. BNet utilizes the definition of "Care Coordination" to mean "the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage". The purpose of the BNet program Care Coordination is to enhance the delivery of treatment services and recovery supports and to improve outcomes among Title XXI

children and adolescents. Care Coordination is not an independent service, but rather a collaborative effort to efficiently target an individual's treatment resource needs, effectively manage and reduce risk, and promote accurate diagnosis and treatment.

6.3.7.1- BH ☒ Intensive wraparound
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Florida Healthy Kids does not cover intensive wraparound services. Medically necessary Intensive Wraparound services unavailable through Florida Healthy Kids coverage may be obtained through the BNet program.

6.3.7.2- BH ☒ Care transition services
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Florida Healthy Kids does not cover care transition services. Medically necessary care transition services unavailable through Florida Healthy Kids coverage may be obtained through the Title XXI CMS Health Plan or the BNet program.

The state references "care transition" services as comprehensive discharge planning (i.e., aftercare, post discharge and follow-up services). These services are provided in accordance with Title 42, CFR, section 441, Subpart D (for providers licensed under the state Rule Chapter 65E-9, F.A.C.). The services are designed to facilitate the successful, therapeutic movement of a child from one setting or set of services to another. The state requires the Statewide Inpatient Psychiatric Program (SIPP) provider to ensure community supports and aftercare treatment are in place prior to discharge. The monitoring of aftercare services is required to determine the appropriateness of the post discharge plan of care and to ensure the discharge plan is correctly implemented. Comprehensive discharge planning includes, but is not limited to:

1. Services recommended by the child/adolescent's treatment team consistent family's strengths and needs.
2. Therapeutic services for the child/adolescent and family or caregiver to prepare for change outside of inpatient treatment.
3. Inclusion of the child/adolescent's assigned targeted case manager in treatment team meetings prior to discharge.
4. Assisting the child/adolescent and family or caregiver locate appropriate provider for delivery of aftercare services and document participation of

planning for post-SIPP services.

5. Referral and coordination to providers of recommended services, including liaison with the receiving school setting and primary medical care provider.

6.3.8- BH ☒ Case Management

Provided for: ☒ Mental Health ☒ Substance Use Disorder

As required by federal law, the state provides services to eligible children if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Child Health Services Targeted Case Management services are available as medically necessary. Case management services are provided through the state CHIP managed care plans. Prior authorization may be required once a member exceeds plan limits/units.

6.3.9- BH ☐ Other

Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☒ Substance Use Disorders

☒ InterQual
☒ Mental Health ☒ Substance Use

The state Managed Medical Assistance Plan may utilize a national standardized set of criteria (e.g. InterQual, MCG Guidelines) or other evidence-based guidelines approved by the Agency to approve services. Such criteria and guidelines shall not solely be used to deny, reduce, suspend or terminate a good or service, but may be used as evidence of generally accepted medical practices that support the basis of a medical necessity determination.

☒ MCG Care Guidelines

☒ Mental Health ☒ Substance Use Disorders

☒ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☒ Mental Health ☒ Substance Use Disorders

☒ CASII (Child and Adolescent Service Intensity Instrument)
☒ Mental Health ☒ Substance Use Disorders

☒ CANS (Child and Adolescent Needs and Strengths)
☒ Mental Health ☒ Substance Use Disorders

☒ State-specific criteria (e.g. state law or policies) (please describe)
☒ Mental Health ☒ Substance Use Disorders

The Behavioral Health Network (BNet) provider agencies are contractually required to use the state prescribed Children's Global Assessment Scale (CGAS). Additionally, all BNet provider agencies use biopsychosocial assessments.

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☒ No specific criteria or tools are required
☒ Mental Health ☒ Substance Use Disorders

Florida Healthy Kids requires the MCOs to adopt evidence-based practice guidelines and encourages the use of validated screening and assessment tools but does not require any specific criteria or tool.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

Florida Healthy Kids requires the MCOs to make information about using validated assessment tools available to providers using the same facilitation strategies as described in section 6.3.1.2-BH.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)

[1] Current Dental Terminology, © 2010 American Dental Association. All rights reserved.

Phase 1 Effective Date: April 1, 1998
Phase 2 Effective Date: July 1, 1998
Revised: 1/26/98, 2/19/98, 3/3/98, 3/6/98
Revised: 8/20/98, 8/24/98, 10/1/99, 7/28/00, 1/31/01, 7/02/02, 7/22/02, 1/3/03, 2/13/04, 9/27/04, 11/15/04, 8/11/05, 10/1/06, 7/1/09, 7/1/10, 7/1/11, 7/1/12, 10/1/12, 8/1/2014, 7/1/2014, 5/1/2015, 7/1/16, 9/1/2017, 10/1/17, 7/1/2018, 3/9/2020, 7/1/2020, 3/11/2021

7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

Children enrolled in the MediKids and Children's Medical Services Network receive the Medicaid dental benefit package, including EPSDT benefits. Children enrolled in Healthy Kids also receive the Medicaid dental benefit package, but do not receive EPSDT benefits.

The services included in the benefits listed above may be limited to services approved through a prior authorization process. Please see Appendix D for information about services that require a prior authorization. The prior authorization requirements are not established based on the dollar value of a service but are designated specialty services or for services that tend to be over-used, abused or need special oversight or care management by the plan. There is a prior authorization exception process in place for emergency situations.

In Appendix D, there are prior authorization guidelines for general dentists to follow when providing endodontic and periodontal procedures. Prior authorizations are required for referrals and treatment provided by Endodontists, Periodontists, Oral Surgeons and Orthodontists. Depending on the plan and the age of the child, prior authorizations may be required for procedures provided by Pediatric Dentists. Routine care provided by General Dentists does not require prior authorization.

Florida Healthy Kids Corporation requires their contracted dental plans to process all prior authorizations requests within fourteen (14) days of the request.

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

☒ State-developed Medicaid-specific - MediKids and CMS Plan
☒ American Academy of Pediatric Dentistry - Healthy Kids enrollees follow the American Academy of Pediatric Dentistry periodicity schedule.
☐ Other Nationally recognized periodicity schedule
☐ Other (description attached)

Florida Healthy Kids requires that the Healthy Kids dental plans include specific standards for the delivery of services, including standards for access to appointments and geographic requirements for primary care and specialty care providers. Plans are also required to submit quarterly claims data on which annual quality measures are scored, including the number of enrollees who received a dental visit and any dental services during the year. Low scores on these measures are often a pre-cursor to network or service issues.

Families contact the KidCare Call Center with concerns when there is immediate access to care issues. Florida Healthy Kids Corporation staff can trouble-shoot these issues as they arise and also tracks them on a long term basis in order to identify systematic problems. Contract provisions provide for Healthy Kids to send children to any willing provider if the Plan is not able to meet contract standards at the Plan's expense. Corrective action plans can also be implemented when necessary.

Both Healthy Kids dental plans have a grievance process in place for enrollees to dispute any denial of services. These processes have also been vetted by Healthy Kids. The processes include informal resolution of issues, as well as formal procedures for when the other avenues have not provided the family the relief being sought. Both plans also have an expedited process for emergency or urgent issues.

6.2.2-DC ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental

Phase 1 Effective Date: April 1, 1998
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Revised: 1/26/98, 2/19/98, 3/3/98, 3/6/98
Revised: 8/20/98, 8/24/98, 10/1/99, 7/28/00, 1/31/01, 7/02/02, 7/22/02, 1/3/03, 2/13/04, 9/27/04, 11/15/04, 8/11/05, 10/1/06, 7/1/09, 7/1/10, 7/1/11, 7/1/12, 10/1/12, 8/1/2014, 7/1/2014, 5/1/2015, 7/1/16, 9/1/2017, 10/1/17, 7/1/2018, 3/9/2020, 7/1/2020, 3/11/2021

services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each

covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD) ICD-10

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☒ Yes

☐ No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

☒ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

MediKids Program – children ages 1 through 4 years

Children's Medical Services Managed Care Plan (CMS Plan) – for children ages 1 through 18 years, with special health care needs

The MediKids Program and CMS Plan enrollees receive Medicaid benefits, including EPSDT services.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance

to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☒ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

☒ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

☒ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

☒ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

☒ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not

preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

☒ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

☒ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

☒ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

The Florida Healthy Kids Program serves children ages 5 through 18 years, but does not offer this population EPSDT benefits. The program does offer comprehensive health benefits and contracts with licensed health plans. The following identified sections apply to the Florida Healthy Kids Program.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

Mental Health and Substance Use Disorder Parity Category Definitions

Inpatient: covered services provided for the medical care and treatment of an enrollee who is admitted as an inpatient to a hospital licensed under Part I of Chapter 395, Florida Statutes, including enrollees admitted as inpatient to a hospital with the expectation of remaining at least overnight and occupying a bed even though the recipient may be discharged or transferred to another hospital and may not use the hospital bed overnight.

- Part I of Chapter 395, Florida Statutes, defines a hospital as any establishment that:
  - Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy
  - Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent, except that a critical access hospital, as defined in s. 408.07, Florida Statutes, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a critical access hospital
  - Excludes any institution conducted by or for the adherents of any well-recognized church or religious denomination that depends exclusively upon prayer or spiritual means to heal, care for, or treat any person.

- Includes "general hospitals" defined as any facility which meets the provisions of the requirements of a "hospital" and which regularly makes its facilities and services available to the general population.
- Includes "specialty hospitals" defined as any facility which meets the provisions of the requirements of a "hospital" and which regularly makes available either:
    - The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population
    - A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders
    - Intensive residential treatment programs for children and adolescents as defined in s. 395.002, Florida Statutes

Outpatient: covered services provided to an enrollee:

- In the outpatient portion of a health facility licensed under Chapter 395, Florida Statutes
- Admitted as outpatient to a health care facility as defined by s. 408.07, Florida Statutes
- At the service location of an office-based provider
- By telemedicine
- Excludes emergency care

Emergency Care: Visits to an emergency room or other licensed facility within the U.S. if needed immediately due to an injury or illness and delay means risk of death or permanent damage to the enrollee's health, including:

- Services by a qualified provider that are needed to evaluate or stabilize an emergency medical condition
- Emergency transportation required in response to an emergency medical condition situation

Prescription Drugs: Drugs prescribed for the treatment of illness or injury, including those prescribed by an enrollee's dental provider under Florida Healthy Kids and excluding drugs provided in an inpatient setting or administered in an outpatient setting.

Covered benefits were categorized based on ICD-10.

6.2.3.1.1 MHPAEA The State assures that:

☒ The State has classified all benefits covered under the State plan into one of the four classifications.

☒ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

☒ Yes

☐ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☒ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☒ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use

disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

There is no aggregate lifetime or annual dollar limits on any mental health or substance disorder benefits for the Healthy Kids population.

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:

☐ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and

surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☒ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not*

impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☒ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

NQTL Analysis Summary and supporting documentation provided as a separate electronic file.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☐ Yes

☒ No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

☐ State

☒ Managed Care entities

☐ Both

☐ Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☐ State

☒ Managed Care entities

☐ Both

☐ Other

PIC Services

Florida assures that it will use Title XXI funding to pay for services provided to children enrolled in the state's SCHIP program only, unless otherwise allowed under Title XXI.

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural

services **(Section 2110(a)(10))**

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

PIC services will be limited to CMSN Title XXI enrolled children with life-threatening conditions and will include counseling services.

6.2.12. ☒ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

PIC services will be limited to CMSN Title XXI enrolled children with life-threatening conditions and will include respite services.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

PIC services will be limited to CMSN Title XXI enrolled children with life-threatening conditions and will include pain and symptom control, nursing, and personal care services.

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☒ Dental services **(Section 2110(a)(17))**

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. ☒ Case management services **(Section 2110(a)(20))**

6.2.21. ☒ Care coordination services **(Section 2110(a)(21))**
Care coordination services is limited to CMSN Title XXI enrolled children.

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

PIC services will be limited to CMSN Title XXI enrolled children with life-threatening conditions and will include expressive therapies.

Expressive therapies include art, music and play therapies. All expressive therapies must be provided by a registered or board certified provider who has documented experience with children. Services provided by counselors who employ the limited use of music, art, dance or play in their counseling are not included in this service category.

These therapies are tied to a specific therapeutic goal in the patient's plan of care. The services are not for recreation but are related to care and treatment related to the individual's health status. The services will be included in the childcare plan.

These are activity therapies intended to encourage children to express fear and anxiety related to their life-limiting condition, treatment, prognosis, or to their ability to cope with what is happening in their life, including family, school, siblings, and friends. These therapies assist the child in expressing the negative fears and anxieties that may be felt but cannot be expressed verbally.

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

Healthy Kids covers emergency medical transportation only.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

These services will be provided to CMSN Title XXI enrolled children with life-threatening conditions and will include supportive over-lay services such as counseling, respite, and other services typically provided by hospice per 42 CFR Ch. IV, Part 418, Subpart F.

6.2.-D The State will provide dental coverage to children through one of the following. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1.-D ~ ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

Children enrolled in the MediKids and Children's Medical Services Network receive the Medicaid dental benefit package, including EPSDT benefits. Children enrolled in Healthy Kids also receive the Medicaid dental benefit package, but do not receive

EPSDT benefits.

The services included in the benefits listed above may be limited to services approved through a prior authorization process. Please see Appendix D for information about services that require a prior authorization. The prior authorization requirements are not established based on the dollar value of a service but are designated specialty services or for services that tend to be over-used, abused or need special oversight or care management by the plan. There is a prior authorization exception process in place for emergency situations.

In Appendix D, there are prior authorization guidelines for general dentists to follow when providing endodontic and periodontal procedures. Prior authorizations are required for referrals and treatment provided by Endodontists, Periodontists, Oral Surgeons and Orthodontists. Depending on the plan and the age of the child, prior authorizations may be required for procedures provided by Pediatric Dentists. Routine care provided by General Dentists does not require prior authorization.

Florida Healthy Kids Corporation requires their contracted dental plans to process all prior authorizations requests within fourteen (14) days of the request.

6.2.1.2-D ~ Periodicity Schedule. The State has adopted the following periodicity schedule:

☒ State-developed Medicaid-specific – MediKids and Children's Medical Services Network follow the Medicaid periodicity schedule. Medicaid follows the American Academy of Pediatric Dentistry periodicity schedule.

☒ American Academy of Pediatric Dentistry - Healthy Kids enrollees follow the American Academy of Pediatric Dentistry periodicity schedule.

☐ Other Nationally recognized periodicity schedule

☐ Other (description attached)

Florida Healthy Kids requires that the Healthy Kids dental plans include specific standards for the delivery of services, including standards for access to appointments and geographic requirements for primary care and specialty care providers. Plans are also required to submit quarterly claims data on which annual quality measures are scored, including the number of enrollees who received a dental visit and any dental services during the year. Low scores on these measures are often a pre-cursor to network or service issues.

Families contact the KidCare Call Center with concerns when there is immediate access to care issues. Florida Healthy Kids Corporation staff can trouble-shoot these issues as they arise and also tracks them on a long term basis in order to identify systematic problems. Contract provisions provide for Healthy Kids to send children to any willing provider if the Plan is not able to meet contract standards at the Plan's expense. Corrective action plans can also be implemented when necessary.

Both Healthy Kids dental plans have a grievance process in place for enrollees to dispute any denial of services. These processes have also been vetted by Healthy Kids. The processes include informal resolution of issues, as well as formal procedures for when the other avenues have not provided the family the relief being sought. Both plans also have an expedited process for emergency or urgent issues.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following**: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the

following **(42CFR 457.1005(a)):**

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system**. The state may cross reference section 6.2.1 - 6.2.28**. **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section**

2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **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 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

7.1.2. ☒ Performance measurement

7.1.3. ☒ Information strategies

7.1.4. ☒ Quality improvement strategies

MediKids

MediKids providers are the same as traditional Medicaid providers. Participating managed care organizations must be licensed by the Office of Insurance Regulation of the Florida Department of Financial Services, in accordance with the Florida Insurance Code, comply with quality of care requirements, which are regulated by the Agency for Health Care Administration, and be accredited by a nationally recognized accreditation entity.

Healthy Kids

- Health Plan Provider Standards

Health plans in the FHKC program must be licensed by the Office of Insurance

Regulation of the Florida Department of Financial Services, in accordance with the Florida Insurance Code. In addition, the insurer must possess appropriate accreditation. All insurers must maintain an adequate network of providers and facilities in order to provide appropriate access to care for all enrollees in their service area.

The insurance product offered must have, or obtain, an approved rate filing with the Florida Department of Financial Services. A utilization management component for inpatient hospital stays, outpatient surgery and selected outpatient services is required.

- Dental Insurer Standards

Dental plans in the FHKC program must be licensed by the Florida Department of Financial Services, in accordance with the Florida Insurance Code. In addition, the dental insurers must maintain an adequate network of providers and facilities to serve the anticipated enrollment in each county.

The insurance product offered by the dental insurers must also have or obtain an approved rate filing with the Florida Department of Financial Services.

- Physician Credentialing Standards

The Florida Healthy Kids Corporation maintains physician-credentialing standards that exceed the standards of the National Committee for Quality Assurance. Specifically, primary care physicians in the network of providers for the Healthy Kids program must meet one of the following criteria:

  - Pediatrician or Family Practitioner with Board Certification; or
  - Physician extenders or members of a residency program directly supervised by a Board Certified Practitioner.

Reasonable exemptions are granted in instances where extenuating circumstances exist. Examples of these exceptions include: rural areas that are unable to meet the access standards without including other health care providers in the network, physicians serving inner city areas, physicians that have been practicing medicine for an exceptional length of time and physicians that are currently serving the required years of practice before taking the examination for board certification. Physicians that require an exemption are reviewed on an individual basis by a qualified group of physicians on behalf of the FHKC.

Healthy Kids also requires its health plans to designate a medical home for each enrollee at the time of his initial enrollment into the plan.

- Facility Standards

Facilities used for Healthy Kids participants shall meet applicable accreditation and licensure requirements and meet facility regulations specified by the Agency for Health Care Administration.

- Access Standards

Both health and dental plans under contract with Healthy Kids are required to meet certain access standards regarding accessibility of primary care medical and dental providers. The contract standard for geographical access to primary care medical and dental providers is twenty (20) minutes driving time from the enrollee's residence to their provider. This time limit is reasonably extended in certain areas of the state.

For specialty care access, the geographic standard is sixty (60) minutes driving time. This standard can also be extended where specialty care services cannot be reasonably obtained within this standard.

- Preventive Care Standards

One of the missions of FHKC is the provision of preventive health services to children. To ensure that children are receiving adequate preventive care, the minimum benefit package was designed in accordance with the "Recommendations for Preventive Pediatric Health Care" as established by the American Academy of Pediatrics.

- Medical Quality Review

The FHKC contracts with an independent quality auditor to evaluate and monitor the quality of care provided by the health plan providers. Objectives of the review are as follows:

  - Review medical records of enrollees to determine compliance with standard elements of documentation supporting the provision of appropriate, quality care.
  - Review care sites to determine compliance with basic safety and infection control requirements and ability to provide access to care within FHKC standards.

- Use review data to determine the sites with specific needs for improvement.
- Assess the effect of the health plan's quality evaluation process on care provided to FHKC enrollees in each county.

Children's Medical Services Network

The CMSN has a series of standards that are used to designate specialty components of the network, such as standards for cardiac programs, craniofacial programs, transplant programs, etc. CMSN also has standards for the designation of hospital facilities in the network.

- Physician Credentialing Standards:

CMSN maintains physician-credentialing standards that exceed the standards of the National Committee for Quality Assurance. Specifically, primary care physicians in the CMSN must meet the following criteria:

- Pediatrician or Family Practitioner with Board Certification; or
- Non-board certified physician applicants who meet requirements for board certification examination might be approved for active status pending completion of board certification. The physician must achieve board certification before their re-approval date.

There is a standard waiver process to grant exceptions to the standard under special circumstances and when in the best interests of the CMSN participants. Examples of these exceptions include: rural areas that are unable to meet the access standards without including other health care providers in the network, physicians serving inner city areas, physicians that have been practicing medicine for an exceptional length of time and physicians that are currently serving the required years of practice before taking the examination for board certification. Physicians that require an exemption are reviewed on an individual basis by CMSN health care staff, the local CMS Medical Director and approved by the Deputy Secretary for Children's Medical Services who is a board-certified pediatrician.

Preventive Care Standards

- CMS providers are expected to use the American Academy of Pediatrics' well-child supervision standards and the periodicity

schedule.

Quality Reviews

CMSN contracts for peer review through a panel of physician consultants. The physician consultants in coordination with CMSN health care staff review, at a minimum:

- medical record content to determine appropriateness of care;
- compliance with program standards; and
- family perception of care.

The CMS will also be a part of the Florida Healthy Kids Corporation evaluation.

Florida's KidCare law authorized the Department of Children and Families to establish behavioral health services standards and practice guidelines for special behavioral health services provided to children with serious emotional disturbance or substance dependence problems. Development of these standards is underway.

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

Providers for the KidCare Medicaid expansion coverage group (newborns to one year old) and MediKids are also Medicaid providers. As such, they are required to comply with the same standards established for the Florida Medicaid program in accordance with Title XIX of the Social Security Act. Details of these requirements are incorporated in Florida's Title XIX state plan.

Healthy Kids Standards: Healthy Kids has established its own minimum standards for quality of care to its enrollees. Health and dental plans contracting with Healthy Kids must meet the following minimum requirements both at the initial contract implementation as well as throughout the contract term:

- Geographical Access Standards
  Primary Care Standards – Medical and Dental Providers

  Geographical access of approximately twenty (20) minutes driving time from the Healthy Kids participant's residence to primary care providers

and primary care dental providers must be provided by the health plan or dental insurer in each program site. The driving time is reasonably extended in areas where this access standard is unattainable, such as rural areas. In such instances, the health plan must provide access to the nearest providers.

Specialty Care Standards

Specialty physician services, ancillary services and specialty hospital services are to be available within sixty (60) minutes driving time from the enrollee's residence to provider. Driving time standards may be waived with sufficient justification if specialty care services are not obtainable due to a limitation of providers, such as in rural areas.

- Timely Treatment Standards

  Timely treatment by health care providers is required, such that the Healthy Kids participant is seen by a provider in accordance with the following:

  - Routine care of patients who do not require emergency or urgently needed care shall be provided within seven (7) calendar days;
  - Physical examinations and routine dental examinations for cleaning and X-Rays shall be provided within four (4) weeks of request for appointment; and
  - Follow-up care shall be provided as medically appropriate.

Children's Medical Services Network

The CMSN uses the same standards as the Florida Healthy Kids Corporation for its medical benefits.

By state law, the Department of Children and Families is authorized to establish the following for the special behavioral services for children with severe emotional disturbances:

- Behavioral health services standards;
- Clinical guidelines for referral to behavioral health services;
- Practice guidelines for behavioral health services to ensure cost-

effective treatment and to prevent unnecessary expenditures; and
- The scope of behavioral health services, including duration and frequency.

The Agency for Health Care Administration monitors these functions on a regular basis to ensure compliance.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR §457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

Healthy Kids
By contract with all its participating health and dental plans, emergency care must be provided immediately; urgently needed care shall be provided within twenty-four (24) hours. When contracts are bid, access to hospital and other urgent care providers is evaluated in order to ensure that enrollees have adequate access to these services. The Agency for Health Care Administration monitors these functions on a regular basis to ensure compliance. All of the FHKC's insurers are also regulated by the Agency for Health Care Administration and the Agency also monitors these functions on a regular basis to ensure compliance with other state and federal requirements.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Healthy Kids
All health and dental plans under contract with Healthy Kids are required to maintain a network of primary care, specialty care and tertiary providers adequate to meet the needs of the Healthy Kids enrollment in a given area. These networks are reviewed closely at the time of bidding and are monitored throughout the contract term. Contracted health plans must be able to provide all of the required benefits, preferably through a network of contracted providers, but may also do so through out of network providers when necessary.

Additionally, FHKC's health plans hold a certificate of authority from the state's Agency for Health Care Administration that also monitors network sufficiency. Both the health and dental plans under contract with Healthy Kids

are required to submit quarterly utilization information to FHKC.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Healthy Kids

In its contracts with its health and dental insurers, Healthy Kids requires its plans to assure their compliance with time standards as well as all other applicable federal or state regulations. This, of course, includes compliance with 42 CFR 495(d).

All decisions related to prior authorization are completed in accordance with state law. The Agency for Health Care Administration monitors these functions on a regular basis to ensure compliance.

MediKids

Providers for the MediKids are also Medicaid providers. As such, they are required to comply with the same standards established for the Florida Medicaid program in accordance with Title XIX of the Social Security Act. Details of these requirements are incorporated in Florida's Title XIX state plan. The plan must assure that primary care physician services and referrals to specialty physicians are available on a timely basis. Requests for prior authorization are handled exactly the same as those for Medicaid participants.

Children's Medical Services Network

The CMS program uses the same standards as the Florida Healthy Kids Corporation for its medical benefits.

By state law, the Department of Children and Families is authorized to establish the following for the special behavioral services for children with severe emotional disturbances:

- Behavioral health services standards;
- Clinical guidelines for referral to behavioral health services; and
- Practice guidelines for behavioral health services to ensure cost-effective treatment and to prevent unnecessary expenditures

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

COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.

8.2.4. ☒ 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.

Florida Healthy Kids Co-payments	
Service	**Co-payment Amount**
Behavioral Health Outpatient Visits	*$5.00 per visit
Emergency Room, Inappropriate Use	$10.00 (waived if admitted)
Emergency Transportation	$10.00 (waived if admitted)
Eyeglasses, Prescription	$10.00
Office Visits, Primary Care	*$5.00 per visit
Office Visits, Specialty Care	*$5.00 per visit
Prescribed Medicine	*$5.00 per prescription
Therapy Services (PT, OT, ST)	*$5.00 per session
Hospice and Home Health Services	*$5.00 per visit
* increases effective October 1, 2003	

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

Florida KidCare Application

In 1998, the original Florida Healthy Kids application was modified to become the first joint Florida KidCare/Medicaid application. Since then, the application has gone through several modifications and is now known as the Florida KidCare application. It includes necessary information for Title XIX eligibility determination as well as the KidCare components (MediKids, Healthy Kids and the Children's Medical Services Network). Families will be informed through a separate brochure that is attached to the application packet that, except for Medicaid, monthly premium payments are required. Schedules of the co-payments for the Healthy Kids program are also included on the Healthy Kids web page, in member materials produced by the participating Healthy Kids health plans and through correspondence sent to families who have begun the application process.

The Florida KidCare application has undergone significant revisions and was distributed beginning March 17, 2003. The application was field-tested with target audiences and includes additional data fields that were not captured on the previous application.

Effective with the January 1, 2004 change to a two-tiered premium of $15 and $20, enrollees received correspondence advising them if their premium changed. The Florida KidCare and Healthy Kids websites were updated to reflect low cost premiums based on family income. The Florida KidCare Information Line also advised families applying that they would be advised of their premium at the time their eligibility is determined.

The KidCare application was revised again in the summer of 2004 in order to address legislative changes with regard to eligibility and verification of income and accessibility to employer-based health insurance coverage.

The Florida KidCare application is reviewed and revised, as necessary, on a regular basis and in order to accommodate legislative and administrative changes to the program. The most recent application revision occurred in 2009 and, as with all major application changes, focus groups were held to review the application for ease of completion and for public input.

Employee Training

The Departments of Health and Children and Families, the Agency for Health Care Administration, and the Florida Healthy Kids Corporation conduct ongoing training sessions for their respective employees to inform them about all of the requirements of the Florida KidCare program, including family cost-sharing and in response to any legislative or administrative change to the program.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☒ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☒ No

Effective January 1, 2021, there will be no costing sharing for outpatient behavioral health and substance abuse services.

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☒ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☒ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

Florida Healthy Kids identified all services to which financial requirements (copayments) apply. Services were categorized into inpatient, outpatient, prescription drugs, and emergency services categories. The $10 copayment requirement for corrective lenses was removed from the analysis as inapplicable.

Florida Healthy Kids applies the listed copayments to the following services without distinction between whether services are for mental health/substance use disorder services or medical/surgical services. The copayments apply to emergency services, outpatient services and prescription drugs only; preventive office visits do not have a copay.

- Emergency services - $10
- Outpatient services
  - Preventive care - $0
  - All other outpatient services - $5
- Prescription drugs - $5

No financial requirements apply to inpatient services. Results: Financial requirements applied to mental health/substance use disorder services are the same as the financial requirements applied to medical/surgical services under the Healthy Kids program.

Effective January 1, 2021, there will be no costing sharing for outpatient behavioral health and substance abuse services.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☒ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☒ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☒ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee. **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

MediKids and CMSN

The maximum annual out-of-pocket premium expenditure per household for these components of the KidCare program does not exceed $180 for families with incomes at or below 158% of the federal poverty level, or $240 for families with incomes above 158% of the federal poverty level. No co-payments or other cost sharing is charged. These amounts are below the 5% threshold.

Healthy Kids

Upon enrollment in KidCare families receive notification of their rights to a maximum cost-sharing allowance of 5% of their annual income. Families are instructed to keep receipts of all cost sharing incurred for their children's health care. In the unlikely instance that a family's out-of-pocket expenses meet the 5% annual income maximum, the family will be instructed to mail a copy of all receipts to FHKC. FHKC will produce a letter to the family indicating that it would no longer be responsible for any provider co-payments for the remainder of the year. The family can show this letter to providers to ensure that they are not charged or otherwise obligated to make any co-payment. FHKC would also ensure that health plans participating in Healthy Kids are made aware of this procedure and instructed to notify their providers of this. In addition, once it has been determined that a family has met its cost-sharing limit, Healthy Kids would no longer require the family to submit a monthly premium payment for the rest of the year.

42 CFR 457.560(b) requires informing the enrollee's family in writing of their individual cumulative cost-sharing maximum amount at the time of enrollment and reenrollment. Effective October 2011, in order to comply with 42 CFR 457.560(b), families will receive notice of their 5% maximum cost sharing amount. This information will be included in their coverage approval letter, renewal notice and other times when an income change would affect the family's 5% maximum calculation. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**
In preparing for the development of a process to identify and notify qualified American Indian tribal members of the Florida KidCare cost-sharing exemption process, the interagency partners of the Florida KidCare Program held an American Indian Cost-Sharing Exemption Workshop. The goal of the meeting was to glean critical input from KidCare partners and from representatives of the tribes on how to develop the most sensitive and effective course of action. Mr. Joe Quetone, appointed by the Governor to serve as the American Indian representative on the Florida KidCare Coordinating Council, was a critical and most valuable participant in that workshop. With his assistance, the following was developed:

1. Exempting qualifying American Indian/Native Alaskan children from Florida KidCare cost sharing: Florida KidCare's system already has in place logic that reflects a "zero" premium for qualifying children. The computer automatically flags the account so that no premium is charged to the family.

2. Identifying qualifying American Indian/Native Alaskan children: KidCare partners have had several meetings with representatives of the Florida tribes to brainstorm on best practices for identifying the uninsured American Indian population. Partners agreed it is valuable to work through the Department of Education and the local school districts, with whom we have already developed an excellent relationship for the enrollment of Florida KidCare children.

3. Notifying the target population of the cost-sharing exemption: Florida KidCare mailed a letter to each of the federally recognized tribes in the State of Florida advising them of the exemption provision for members of their tribes enrolled in the Florida KidCare Program. We requested that they share this information with their population and to have tribal members contact us at our toll-free KidCare helpline to ask questions or obtain more information.

In addition, Families are prompted to call a "Special Unit" telephone number at the Healthy Kids Tallahassee call center. The staff answering the Special Unit telephone number will be knowledgeable about the AI/AN cost-sharing exemption and will answer the family's questions about KidCare and determine whether any children in the family may be eligible for the cost-sharing exemption. If the staff person answering the Special Unit telephone number is not available, callers may leave messages on voicemail and their calls will be returned promptly.

The staff at the Special Unit telephone number will tell the family to send in proof of federally recognized tribal status. The family should submit a copy of the child's tribal membership card. The family account number should be written on each copy of a tribal affiliation document.

The KidCare application was revised effective January 2003, to include a race question. If the family indicates a child is American Indian or Alaskan Native, but does not provide tribal membership documents, a letter will be sent by the TPA requesting this information in order for full-premium subsidy to occur if the child is determined otherwise eligible.

Upon receipt of the application and proof of federally recognized tribe status, Healthy Kids will identify and flag the child's account as an AI/AN account.
Once an account has been flagged as an AI/AN account, the system will not require premiums to be paid on the account, will not cancel the account for non-payment, will not generate late notices, etc., provided that the child meets all other Title XXI criteria in order to qualify for waiver of premium.

For example, a child who presented acceptable tribal documentation to qualify as AI/AN but whose household income is at 300% FPL will NOT qualify for a premium waiver. As long as there is at least ONE active AI/AN child in a family of multiple children, the $15 or $20 monthly premium will be waived for all. If the AI/AN child ceases to be active, then the other children will have to resume monthly payments. Children whose accounts have been flagged as AI/AN accounts will receive a letter which states that they are exempt from cost-sharing, which the children can present to their providers to be exempted from any required co-payments, if applicable.

8.6 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

Under state law, 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.

Premium payments are due on the first day of the month of coverage and are considered late after that date. Families receive a coupon book upon initial enrollment that indicates the amount of the monthly premium and the day the premium is due for each month. Families are given the opportunity to make late premium payments during the 30 day grace period.

If premium payments to FHKC are not received by the seventh day of the month prior to coverage, they are considered late and the families receive written notification that they will be canceled at the end of the month, and the consequences of cancellation.

If a payment is posted to the wrong account, or if another error caused by FHKC or its TPA causes a child's coverage to be canceled, FHKC will reactivate the coverage.

If the TPA has not received a premium payment for a child during the grace period coverage for that child will be canceled. The family will receive written notification of that cancellation.

Disaster Relief Provision - Exception to Disenrollment for Failure to Pay Premium

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 for a specified period of time for CHIP enrollees who meet income and other eligibility requirements and who reside and/or work in Governor or FEMA declared disaster areas.

The determination that an enrollee resides and/or works in a Governor or FEMA declared disaster area is based on self-declared application, renewal information or other documentation provided by the family.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR**

457.570(a))

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**

Families may contact the TPA through the toll free number at anytime to report changes in income or household size over the telephone.

☒ In the instance mentioned above, that the state would facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))** The Florida KidCare program as well as the Healthy Kids program has developed dispute resolution procedures to handle grievances and complaints from enrollees and applicants to the program.

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost sharing (including premiums, deductibles, co pays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the

mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Objective One: Improve the health status of children in Florida.
Objective Two: Maximize consumer health plan choices.
Objective Three: Increase the number of children who have access to health care.
Objective Four: Ensure that families leaving the TANF program have access to affordable health care coverage for their children.
Objective Five: Reduce the instances of hospitalization for medical conditions that can be treated with routine care (e.g., asthma and diabetes).

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

Objective One: Improve the health status of children in Florida.

- Percent of parents with children enrolled in the Florida KidCare program that report improved health status of their children.
- Percent of children who have age-appropriate immunizations.
- Percent of children in each Florida KidCare program component whose health care is in compliance with the established Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics.
- Percent of children in Florida Healthy Kids project sites whose preventive dental care is in accordance with the

standards set by the American Academy of Pediatric Dentistry.

Objective Two: Maximize consumer health plan choices.

- Percent of children with special health care needs who select the Children's Medical Services Network.

Objective Three: Increase the number of children who have access to health care coverage.

- Percentage increase in uninsured children who enroll in the Florida KidCare program.
- Percentage increase in children who are eligible for Medicaid and enroll.
- Percent of enrollees or enrollee's families who indicate satisfaction with the care provided under the Florida KidCare program component in which they are enrolled.
- Percent of Florida KidCare enrollees who have access to dental services.

Objective Four: Ensure that families leaving the TANF program have access to affordable health care coverage for their children.

- Percent of families leaving the TANF program after exhausting the 12 months of transitional Medicaid benefits and whose children lose financial eligibility for Medicaid who enroll their children in the Florida KidCare program.
- Percent of former TANF families whose children continue to be eligible for Medicaid and who use Medicaid services. Percent of TANF families who disenroll from Florida KidCare for non-payment of premiums.

Objective Five: Reduce instances of hospitalization for medical conditions that can be treated with routine care (e.g., asthma and diabetes).

- Percent of children admitted as inpatients for asthma.

- Percent of children admitted as inpatients for diabetes.
- Percent of hospitalizations in each Florida KidCare component for ambulatory sensitive conditions.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A), (B)) (42CFR 457.710(d))

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.

MediKids

The Agency for Health Care Administration reports the combined CHIP and Medicaid rates for the Children's Core Set of Health Care Quality Measures in the CHIP Annual Report.

Healthy Kids

A variety of encounter data are collected from the participating health plans and its dental insurers. This information is crucial to the ongoing evaluation and monitoring of the FHKC program.

A quarterly file is prepared by each participating health and dental plan. The file reflects claims and encounters entered during the quarter

and are delivered to FHKC's contracted evaluators, ICHP. The required data fields are subject to change in order to meet the program's needs and to adapt to changes in technology and health care.

Other
Information will be obtained from existing databases, the sources of information described earlier, focus groups and surveys. Additional data can also be collected from health and dental plans, the Florida Medicaid program and focus groups. Surveys will be conducted for children currently enrolled in the Florida KidCare program and children who disenroll from the program.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well child care
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6. ☒ Dental care
- 9.3.7.7. ☐ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

In compliance with each of the requirements of 42 CFR 457.750, the Agency for Health Care Administration prepares an annual report to CMS on the results of the State's assessment of the operation of the State plan. The development of the report includes input from each of the Florida KidCare partners representing Florida Healthy Kids, the Children's Medical Services

Network, the Behavioral Health Network, the Department of Children and Families, and MediKids. The Agency also utilizes the data collected from the University of Florida's Institute for Child Health Policy, which has a contract to produce an annual evaluation of the Florida KidCare Program.

The annual evaluation looks at various issues such as:

- Application and enrollment information
- Point in time enrollment figures
- Time elapsed from application to enrollment
- Out of pocket expenditures incurred while awaiting KidCare coverage
- Immunization compliance
- Reasons for disenrollment

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public

involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

Beginning in September 1997, the Florida Legislature began meeting to discuss Florida's child health insurance plan. Public discussion was encouraged at the legislative committee meetings. By November 1997, five legislative committees convened more than one dozen public meetings to discuss issues relating to creating and implementing Title XXI programs. There was also an extensive public comment process during the 1998 legislative session, which resulted in the passage of the Florida KidCare Act.

The Healthy Kids program is overseen by a board of directors, which meets on at least a quarterly basis. These meetings as well as meetings of its committees and subcommittees are publicly noticed and board meeting materials are posted to the web for public viewing prior to each meeting.

Additionally, in the enabling legislation for the Florida KidCare program, the KidCare Coordinating Council was established and is chaired by Florida's Secretary for the Department of Health. The purpose of the Council is to review and make recommendations to the Governor and the state legislature concerning the implementation and operation of the program. The Act requires that the Council representatives include each of the KidCare partner agencies as well as the Department of Financial Services, local government, health insurers, health maintenance organizations, health care providers, families participating in the program, and organizations representing low-income families.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR §457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Florida has two federally recognized Native American Tribes: The Seminole Tribe and the Miccosukee Tribe. Native Americans represent less than 1% (0.28%) of Florida's population of 14.9 million in 1998. Approximately 9,200 Native American children reside in Florida (*1997 Kids Count: Profiles of Child Well-Being*, Annie E. Casey Foundation). Native American children under age 19 represent less than one-half of one percent of the approximately 715,000 children enrolled in Medicaid (about 349 children under age 19 enrolled in Medicaid are Native Americans).

Applications are sent to the two Native American Tribes for distribution on a regular basis.

Joe Quetone, the Executive Director of the Florida Governor's Council on Indian Affairs, is a member of the KidCare Coordinating Council, an oversight and advisory body; and as such, participates in making recommendations to the Governor and legislature regarding the Florida KidCare Child Health Insurance Program.

The Agency for Health Care Administration contacted the Seminole and Miccosukee Tribes and established the following process for tribal consultation. The Agency will send a letter to each tribe thirty (30) days in advance of amending the CHIP State Plan to provide the tribes an opportunity to provide comments or suggested changes. The Agency will review all comments and make any appropriate changes.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

The 2003 Florida Legislature made several statutory changes to the Florida KidCare Program's enabling legislation and adjusted the funding for the Florida KidCare Program based on several program modifications including:

- Effective July 1, 2003, the family premium payment is increased from $15 per family per month to $20 per family per month for all Florida KidCare Program components (non-Medicaid). Effective January 1, 2004, the family premium will be $15 for families with income less than or equal to 150% of the federal poverty level and $20 for families with incomes from 150.01% to 200% of the federal poverty level. In addition, in January 2004, families with incomes at or under 150% of the Federal Poverty Level were provided with premium credits of $5 for each month in which their child was enrolled between August and December 2003 (if their family incomes were also at or under 150% of the Federal Poverty Level for those months);

- Effective July 1, 2003, dental benefits were capped at $750 per enrollee per year (July 1 – June 30) for children enrolled in the Florida Healthy Kids

program; and,

- Effective October 1, 2003, co-payments are increased from $3 to $5 for certain health care services for children enrolled in the Florida Healthy Kids program.

In addition to the statutory changes, the 2003 Florida Legislature eliminated funding for outreach for the KidCare Program; and appropriated funds the existing enrollment estimated for June 30, 2003.

A press release was issued on June 4, 2003 by the Department of Health announcing the July 1, 2003 changes to the Florida KidCare program. The press release included information regarding the waiting list, the monthly premium increase and the Healthy Kids program specific changes. The Healthy Kids changes announced were the $750 dental cap per year and the co-payment increase to $5 for certain health services.

Eligibility changes that are to be effective July 1, 2004 and at redetermination for current enrollees have been heavily covered in the Florida media for the three months prior to passage of the legislation. Additionally, information about the changes was posted to the Florida Healthy Kids website within days of the Governor's signing the bill on March 11, 2004.

Additionally, the KidCare Program partners will prepare correspondence to enrolled members about the upcoming changes and will host a series of regional meetings in May 2004 to inform the public about these changes and to solicit input on implementation of some of the changes. Other public meetings of the Florida KidCare Coordinating Council and the Florida Healthy Kids Corporation, all of which are publicly noticed, will also address the upcoming changes.

In addition to the Florida KidCare Coordinating Council meeting and the Florida Healthy Kids Corporation's board of Directors meetings, which are publicly noticed, Florida Healthy Kids Corporation hosted four regional meetings in June 2009 for community organizations and advocates to discuss state and federal legislative changes and outreach.

Florida Healthy Kids Corporation notified Healthy Kids enrollees about the elimination of the annual dental benefit limit effective July 1, 2010 by sending

all Healthy Kids families a special letter, in addition to a family newsletter that provided information. The Healthy Kids dental plans were also required to update their member materials to reflect the benefit change. A two month open choice period was held prior to July 1, 2011, to allow families to change their Healthy Kids dental plan.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation;
  - Assumptions on which the budget is based, including cost per child and expected enrollment; and
  - Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

School Health Services Initiative

- Disbursement of Title XXI Funds for the School Health Services Initiative

  The 46 county health departments that participate in the Comprehensive School Health Services Program were initially selected through a request for proposal process (RFP). Sixty-six of Florida's sixty-seven county health departments receive funding to implement Full Service School programs.

  To receive Title XXI federal funds, the participating county health departments record their expenditures to a specific Cost Accumulator (OCA) in the state's FLAIR accounting system. DOH Bureau of Revenue Management Office submits monthly vouchers for Title XXI federal reimbursement to the Agency for Health Care Administration (AHCA); the Department of Health applies an adjustment factor that reduces the federal amount requested to account for children enrolled in Medicaid and children ages 19 or over.

  After AHCA transmits the Title XXI federal reimbursement to the Department of Health, the Department's Office of Revenue Management disburses the funds directly

to each of the participating county health departments' trust fund accounts based on their reported expenditures.

The Department of Health Comprehensive and Full Service School Health Services Programs provided funding for the following during the most recent year (2010) for which data is available:

- 662.15 comprehensive and full service school health FTEs hired by county health departments and 163.81 full service school positions hired by local school districts (through contractual agreements) located in participating schools in 66 counties. Twenty-one of the Department of Health county health departments contract with their local school districts to provide full service school services. To avoid the possibility of double-billing for the contracted staff through the Medicaid administrative claiming program and the Department of Health Title XXI school health initiative, the Department of Health backs out Medicaid enrolled students in its computation of the rate adjustment factor used for calculating federal reimbursement. Should a county health department choose to contract either or both its comprehensive and full service funds to a local school district, the resulting expenditures will be used to draw down the federal appropriation. Distinguishing between services funded by Title XXI funds and those funded by Title XIX funds:

Florida will adopt a conservative methodology to discount the amount it claims in Title XXI funding to account for children who are enrolled in Medicaid and children ages 19 or over.

The state will distinguish between services paid for with Title XXI federal funding and Title XIX federal funding from a cost pool methodology based on expenditures submitted by county health departments for the Comprehensive and Full Service School Health Programs, reduced by an adjustment factor for students who are either enrolled in Medicaid or who are age 19 or older. The Florida Department of Health Comprehensive School Health Program also provides services to certain children under age five who attend schools that participate in the program. However, as an additional safeguard against duplicate billing, the state will not claim Title XXI funds for these children.

The following methodology shows the calculation for the adjustment factor that will be used to reduce expenditures from the cost pool for students who are ineligible for Title XXI funding. The calculations are based on school enrollments (minus children

under age 5 or age 19 or older) and Medicaid enrollment in the 66 Florida counties.

TITLE XXI BILLING METHODOLOGY FOR 66 COUNTIES (adjustment factor)	
Students in 66 Florida county schools (Pre-K to 12th grade) for 2009-2010	= 2,555,310
Number of Medicaid children in 66 counties ages 4 through 18 (7/2010)	= 914,731
Students in Kindergarten-12th grade age 19 or older	= 16,000
Students in Kindergarten-12th grade less ineligible students	= 1,624,579
Adjustment Factor (1,624,579/2,555,310):	0.0.636
The calculation for federal Title XXI Reimbursement is: *Expenditures for the quarter x 0.636 x FMAP = Amount of Title XXI federal funds requested*	

SUMMARY: The Florida KidCare Program uses Title XXI administrative funds to:

- Provide Comprehensive and Full Service School health services to eligible students in 66 out of 67 counties in the state;
- Assure that no duplicative billing (Title XIX and Title XXI) will occur in this program by backing out Medicaid enrolled students in its computation of the adjustment factor for calculating state match and in this manner increasing the amount of state match funds required to receive Title XXI.
- Purge from the claiming methodology all children under age 5 or age 19 and older.
- The total School Health Services Initiative cost appears as a separate line under Administrative Costs in the CHIP Budget Plan Template. The amount shown represents the amount appropriated by the Florida Legislature. For the SFY 2011/2012, the Florida Legislature appropriated a total of $ 17 million for the

School Health Services Initiative. Out of the $17 million appropriated, $11.8 million was Title XX funding. This was an increase of $ 4.3 million. For SFY 2012/2013, the Florida Legislature appropriated a total of $16.5 million for the School Health Services Initiative. Out of the $16.5 million appropriated, $11.6 million was Title XXI funding.

PIC services will be paid for within the existing Title XXI CMSN per member per month budget. These additional services will be budget neutral due to an expected decrease in in-patient hospital services and emergency room services the children receiving PIC services will incur.

The emphasis of PIC services is twofold. First, PIC services will be able to provide care in the home, decreasing the amount of care provided by inpatient facilities. Secondly, PIC will provide enhanced psychosocial interventions that will better prepare families to handle crises that arise and more comfortably deal with the child staying at home, thus decreasing hospital admissions. It is further anticipated that the frequency of emergency room visits will decrease.

SCHIP Budget Plan Template
Fiscal Year – –2014 - 2015

	Federal Fiscal Year Costs
Enhanced FMAP rate	**71.80**
Benefit Costs	
Insurance payments	
Managed care	
per month rate $ $138.038 @ 3,679,416 member months	507,899,226
Fee for Service	0
Health Services Initiatives	0
Total Benefit Costs	**507,899,226**
(Offsetting beneficiary cost sharing payments)	30,516,389
Net Benefit Costs	**477,382,837**
Administration Costs	
Personnel	
General administration	10,934,430
Contractors/Brokers (e.g., enrollment contractors)	22,231,808
Claims Processing	
Outreach/marketing costs	1,200,000
Other (Full Service School Health Services)	12,040,544
Total Administration Costs	**46,406,782**
10% Administrative Cost Ceiling	53,042,537
Federal Share (multiplied by enh-FMAP rate)	376,080,946
State Share	147,708,673
TOTAL PROGRAM COSTS	**523,789,619**

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.
Note: Source of state share are:
General Revenue: $ 147,708,673
Tobacco Funds: $ 0
Assumptions: Dental
SFY 09/10 Healthy Kids per member per month: $11.10, $1,000 cap

Phase 1 Effective Date: April 1, 1998
Phase 2 Effective Date: July 1, 1998
Revised: 1/26/98, 2/19/98, 3/3/98, 3/6/98
Revised: 8/20/98, 8/24/98, 10/1/99, 7/28/00, 1/31/01, 7/02/02, 7/22/02, 1/3/03, 2/13/04, 9/27/04, 11/15/04, 8/11/05, 10/1/06, 7/1/09, 7/1/10, 7/1/11, 7/1/12, 10/1/12, 8/1/2014, 7/1/2014, 5/1/2015, 7/1/16, 9/1/2017, 10/1/17, 7/1/2018, 3/9/2020, 7/1/2020, 3/11/2021

SFY 10/11 Healthy Kids per member per month: $11.99, no cap
SFY 12/13 Healthy Kids per member per month: $ 12.59
Health
SFY11/12 Healthy Kids and MediKids health plan rate freeze
SFY 14/15 Healthy Kids per member per month dental rate: $12.98

The policy change regarding provisional CHIP coverage in SPA #23 coverage has no discernible budget impact.

In 2009, the Healthy Kids program implemented the Medicaid Prospective Payment System for federally qualified health centers and rural health centers. The Florida Legislature appropriated $8,268,156 in additional funding in SFY 2009/2010 for Florida Healthy Kids Corporation (FHKC) to amend their health plan contracts effective October 1, 2009 to require Medicaid PPS and to increase the capitation rates to cover the cost of implementing the Medicaid PPS for FQHCs and RHCs. Since SFY 2009/2010, the funding for PPS has been included in FHKC's overall legislative appropriations for health and dental services with no additional budget impact. The MediKids and Title XXI Children's Medical Services Network have always reimbursed FQHCs and RHCs according to the Medicaid Prospective Payment System, so this policy did not have a budget impact for these programs.

The premium level change to comply with MAGI conversion in SPA #25 has no discernible budget impact.

SPA FL-17-0028-CHIP – Disaster Relief Provisions
There is no fiscal impact until the State decides to implement some or all of the disaster relief provisions.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1), (2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-D ☒ Section 10.3-D □ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required for posting on the Insure Kids Now! Website.

Section 11. Program Integrity (Section 2101(a))

☐ **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 to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

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

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR §457.1120.

Assurances

In compliance with 42 CFR §457.1120, Florida KidCare has a program specific review that meets the requirements of §§457.1130, 457.1140, 457.1150, 457.1160, 457.1170, and 457.1180.

The review process ensures that an applicant or enrollee has an opportunity for review, consistent with §§457.1140 and 457.1150 of a –

(1) Denial of eligibility;

(2) Failure to make a timely determination of eligibility; and

(3) Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing; in establishing the Florida KidCare Act in July of 1998, Florida legislators provided in Section 409.8132 (9), penalties for voluntary cancellation, that "the agency shall establish enrollment criteria that must include penalties or waiting periods of not fewer than 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of premiums." However, if an enrollee appeals termination of coverage for non-payment KidCare codes the system for a "0" premium and continues benefits until the dispute is resolved. Coverage continues during that period. Should the situation not be resolved in the enrollee's favor, the enrollee will be disenrolled for the 30-day period prescribed by state law.

(4) Additionally, the review process ensures that an enrollee has an opportunity for external review of a delay, denial, reduction, suspension, or termination of health services in a timely manner. Each review is conducted independently, since the individuals involved in reviews are not involved in application/eligibility processing.

Should any of the above actions be the result of automatic changes in eligibility, enrollment,

or a change in coverage under the KidCare benefits package that affects all applicants or enrollees or a group of applicants or enrollees with regard to their individual circumstances, then those actions are not considered disputable.

All actions related to application processing for Florida KidCare, such as enrollment, disenrollment, payment of premiums, and provider choice are communicated to applicants/enrollees in writing.

Description of the Florida KidCare Review Process

All applicants and all enrollees initiate impartial review in the same way, regardless of the level of complaint. Since eligibility is determined by the Healthy Kids' computer system, impartial review is triggered for the first time when the individual calls with a complaint and speaks to a Healthy Kids staff person.

That first contact can be either in writing or by telephone with FHKC, expressing their dissatisfaction with a disputable action. In those cases where the applicant/participant requests a hearing to resolve a dispute, a comprehensive series of procedures has been developed to address the matter in question. The procedures are detailed in attachment B, "Florida KidCare Dispute Review Process."

The Dispute Review Process addresses the denial of eligibility and failure to make a timely determination of eligibility, as well as termination of enrollment. Regarding disenrollment for failure to pay cost sharing, families required to pay a monthly premium are advised that the premium is due on the first of the month prior to coverage (the premium for February coverage is due January 1st). If payment is not received by the 7th, a late notice is sent out to the family. Families have the opportunity to call if they have any questions or to advise FHKC that they have already submitted payment. Families are afforded every opportunity to submit their payment in a timely manner. Enrollees will have coverage the following month if the premium payment is received by the last day of the current payment month (the premium for February coverage must be paid by January 31).

The following table illustrates the established review processes for each component of Florida KidCare.

REVIEW PROCESSES FOR FLORIDA KIDCARE		
	Health Services	**Enrollment**
Florida Healthy Kids	Medical Provider Internal Dispute Process	• Florida KidCare Dispute Process • Florida KidCare Grievance Committee
MediKids	Medical Provider Internal Dispute Process	• Florida KidCare Dispute Process • Florida KidCare Grievance Cmte
Medicaid	Medicaid Fair Hearing Process	Medicaid Fair Hearing Process
Children's Medical Services Network	Medical Provider Internal Dispute Process	• Florida KidCare Dispute Process • Florida KidCare Grievance Committee

Florida statutes afford families a wide array of consumer protections for recourse when they wish to challenge any decisions. Some of the options include:

- Children's Medical Services Advisory Council
- HMO Grievance Process
- Statewide Subscriber Assistance Panel
- Florida KidCare Grievance Committee
- Florida Healthy Kids Board of Directors
- Medicaid Fair Hearing Process (for applicants/enrollees in Title XIX Medicaid)

For Issues Specific to Eligibility and/or Enrollment:

Florida KidCare sends applicants and enrollees timely written notice of determinations regarding eligibility or enrollment matters. Notices mailed to applicants/enrollees contain language and timeframes consistent with 42CFR 457.1180. The state will distribute a brochure that lists all of the rights and responsibilities of enrollees.

In its role of central processor for the Florida KidCare Program, Florida Healthy Kids has developed a comprehensive procedure for conducting reviews of eligibility or enrollment matters. This procedure ensures that any reviews are resolved within 90 days, consistent with 42 CFR 457.1160(a).

The resolution coordinator shall supervise the dispute process and prepare a written response to the applicant/participant explaining FHKC's decision regarding the member's eligibility

and enrollment. The response shall include: 1) a brief summary of the dispute, 2) the reasons for FHKC's decision, 3) an explanation of applicable right to review of that determination, 4) the standard and expedited time frames for review, 5) the manner in which a review may be requested, and 6) the circumstances under which enrollment may continue pending review.

The resolution coordinator should involve all parties necessary to resolve the applicant/participant's dispute. Disputes that substantively involve more than one KidCare entity should be immediately referred to the KidCare Grievance Committee. The resolution coordinator must notify the applicant/participant of the referral to the KidCare Grievance Committee in writing.

The resolution coordinator (or designee) will acknowledge receipt of the dispute within three (3) calendar days of receipt. Resolution of the dispute shall be sent to the applicant/participant in writing within fifteen (15) calendar days after FHKC's receipt of a written request to initiate the dispute review process.

The resolution coordinator may extend the time frames listed above to accommodate any necessary additional research, or for other appropriate reasons. The applicant/participant shall be promptly notified of any extension. Every effort will be made to prevent such an extension from lasting longer than 30 days. The resolution coordinator shall make every effort to ensure that no dispute review process remains unresolved longer than 90 days.

Pursuant to 42 CFR 457.1140(d)(1)(2) and (3), Florida KidCare developed this review process to ensure that any applicant/enrollee has the opportunity to represent themselves or have representatives of their choosing involved in the review process. In addition, applicants and enrollees are entitled to timely review of their files and any other applicable information relevant to the review of the pending decision, and to participate in the review process, whether in person or in writing. All reviews must be completed within 90 days. For details about the review process, please see the enclosed Dispute Review Process.
All decisions are written consistent with 42 CFR 457.1140 (c).

The Florida KidCare Dispute Review Process and Grievance procedures are included in Appendix B and C.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR §457.1120.

Assurances

- The Florida KidCare program has a process for program specific review that meets the requirements of §§457.1130, 457.1140, 457.11450, 457.1160, 457.1170, and 457.1180.

- All Florida KidCare applicants or enrollees have the opportunity for independent review consistent with §§457.1140 and 457.1150, of a health services matter, such as delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and failure to approve, furnish, or provide payment for health services in a timely manner, unless the sole basis for the decision is a provision in the Florida KidCare State Plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances. If there is an immediate need for health services, the State will provide an expedited review.

- Florida KidCare assures that reviews related to health service matters are conducted by an impartial person or entity in accordance with §457.1150; review decisions are timely in accordance with §457.1160; review decisions are written; and applicants and enrollees have an opportunity to represent themselves or have representatives of their choosing in the review process; timely review their files and other applicable information relevant to the review of the decision; fully participate in the review process, whether the review is conducted in person or in writing, including by presenting supplemental information during the review process and receive continued enrollment in accordance with §457.1170.

- Florida KidCare assures that an enrollee has an opportunity for an independent external review of matters described in §457.1130(b). External reviews are conducted by the State or by a contractor, other than the contractor responsible for the matter subject to external review.

- Florida KidCare ensures that reviews are completed in accordance with the medical needs of the patient. If the medical needs of the patient do not dictate a shorter time frame, reviews are completed within the time frames set forth in §457.1160: within 90 calendar days of the date an enrollee requests the review; or within 72 hours if the enrollee's physician or health plan determines that operating under the standard time frame could jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. Florida KidCare may extend the 72-hour period by up to

14 calendar days if the enrollee requests an extension.

- Florida KidCare ensures the opportunity for continuation of enrollment pending the completion of reviews as required in 42 CFR§457.1170.

- Florida KidCare provides enrollees and applicants timely written notice of all determinations as required in 42 CFR §457.1180.

Process Description

The Florida Healthy Kids Corporation serves the Florida KidCare Program in two capacities. The Corporation is a service provider for children ages 5 and over, and it also contracts with the Agency for Health Care Administration to perform as the central processor for Florida KidCare. In this capacity, they process each application for enrollment, regardless of the KidCare component for which the child qualifies.

REVIEW PROCESSES FOR FLORIDA KIDCARE		
	Health Services	**Enrollment**
Florida Healthy Kids	Medical Provider Internal Dispute Process	• Florida KidCare Dispute Process • Florida KidCare Grievance Committee
MediKids	Medical Provider Internal Dispute Process	• Florida KidCare Dispute Process • Florida KidCare Grievance Committee
Medicaid	Medicaid Fair Hearing Process	Medicaid Fair Hearing Process
Children's Medical Services Network	Medical Provider Internal Dispute Process	• Florida KidCare Dispute Process • Florida KidCare Grievance Committee

Florida's SCHIP utilizes the same review processes in place for contracted providers of health services in Title XIX, all of which comply with 42 CFR §457.1120.

For the Healthy Kids program, FHKC contracts with licensed health and dental insurers who assume the responsibility for providing the benefits covered under the Healthy Kids program. In these contracts, the plans also have the responsibility to have review processes in place that conform with all federal and state requirements. The specific steps taken by each plan may

vary, but all of the plans are required, by contract, to meet the specific time standards as detailed in the SCHIP regulations. Participating plans are also monitored by the Agency for Health Care Administration for compliance with all state requirements in this regard as well.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR §457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Appendix A
KidCare Medicaid Screening Criteria

Eligibility Levels

- Children 0 up to age 1, 200% of the most recent Federal Poverty Level (FPL)
- Children 1 up to age 6, 133% FPL
- Children 6 up to age 19, 100% FPL

Standard Filing Unit Policy

- Intact Family
  a. Defined as a family where both the child's mother and father are living in the home.
  b. All income counted, including Social Security benefits (see "Income Disregards" for exceptions).
  c. Family size = mother + father + child(ren).
  d. Adoption is considered parentage.
  e. Siblings and their income may be excluded if it makes the child potentially Medicaid eligible.
  f. First, test all family members together at 100% FPL.
  g. Exclude mutual children from any deprived child's filing unit.
- Single Parent Households
  a. Defined as a family where only one parent is in the home.
  b. All income counted, including Social Security benefits - see Section III for exceptions.
  c. Family size = one parent + child(ren).
  d. First, test all family members together at 100% FPL.
  e. Siblings and their income may be excluded if it makes the child potentially Medicaid eligible.

- Non-Parent Households

  a. Defined as any child not living with a parent in the household. May be living with a relative or a non-related adult.

  b. Income of child is counted (except for earned income of full-time students) - see Section III for explanation.

  c. Income of adults is not included.

  d. Family size = number of children only.

  e. Siblings and their income may be excluded if it makes the child potentially Medicaid eligible.

- Households with Stepparents - no mutual children

  a. Includes any household with a stepparent and natural parent(s).

  b. Only count natural parent when determining the child's eligibility.

  c. Siblings and their income may be excluded if it makes the child Medicaid eligible.

- Households with Stepparents – with mutual children (blended)

  a. Stepparent and natural parent with at least one mutual child in the household.

  b. Test 1 includes all family members together at 100% FPL.

  c. Test 2 excludes mutual child from deprived child's filing unit.

  d. For mutual children, include deprived siblings.

Income Disregards

- Siblings with Income and Student Earned Income

  a. Siblings with income may be excluded (both income and in determining household size) when exploring eligibility or the other siblings if it makes the other sibling potentially Medicaid eligible.

  b. The earned income of a full-time student is disregarded unless the student is the parent applying for a child.

- Disregards to Income

1. Each person whose earnings are counted will receive a $90 disregard for earned income.
2. Child support income will get up to $50 disregard per family when testing at the family level. Child support income will get up to a $50 disregard per child when testing at the child level.
3. Child support paid for a child living outside of the household is disregarded against the income (earned or unearned) for the parent who paid it up to the amount indicated in the court-order.
4. Child/Day care will be disregarded to the following limits provided at least one parent is working and the child care is for the child or the child's sibling(s) up to age 13:
   - Up to $200 a month per child in daycare for each child under age 2.
   - Up to $175 a month for daycare for each child/member in daycare age 2 or over.
5. SSI income
   - The person who receives SSI is not considered part of the filing unit.
   - SSI income is not counted.

Appendix B
Florida KidCare
Dispute Review Process

Title:

Review Process for Eligibility, Enrollment, and Health Services Disputes.

Purpose:

To provide a review process for eligibility, enrollment, and health services disputes submitted by applicants and participants.

Objectives:

To make every effort to thoroughly and equitably conduct a review process for eligibility and enrollment disputes, and a referral process for health services disputes within specified time frames

Policy Statement:

The Florida KidCare Dispute Review Process is the means by which the Florida KidCare Program provides a comprehensive review of complaints relating to eligibility and enrollment. During the review process, complaints or disputes are investigated and resolved for eligibility or enrollment matters regarding:

(a) Denial of eligibility;
(b) Failure to make a timely determination of eligibility; and
(c) Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

Health service matter disputes regarding a delay, denial, reduction, suspension, or termination of health services and failure to approve, furnish, or provide payment for health services in a timely manner are reviewed and resolved through a process developed independently for each Florida KidCare program entity as referenced in Rule 59G-14.007, F.A.C.

The Third Party Administrator for the Florida Healthy Kids Corporation determines eligibility and processes informal disputes received during "Level One" of the dispute review process for the non-Medicaid components of the Florida KidCare Program. The Florida Healthy Kids Corporation is responsible for reviewing the formal eligibility and enrollment disputes for the

Florida KidCare Program. The Florida Healthy Kids Corporation Resolution Staff is responsible for conducting the Florida KidCare Dispute Review Process.

The Florida KidCare Dispute Review Process is comprised of four review levels addressing the denial of eligibility, failure to make a timely determination of eligibility and suspension or termination of enrollment, including disenrollment for failure to pay the family premium. The Florida Healthy Kids Corporation shall provide information regarding the dispute review process in correspondence to families, making them aware of the existence and availability of the Florida KidCare Dispute Review Process.

Definitions

(1) "Applicant" refers to a parent or guardian of a child or a child whose disability of nonage has been removed under Chapter 743, F.S., who applies for eligibility under Sections 409.810-.820, F.S. (Florida KidCare Act).

(2) "Complaint" or "dispute" is a verbal or written expression of dissatisfaction, regarding an eligibility or enrollment decision received within 90 calendar days of the date of the letter indicating the suspension or termination of a child's enrollment.

(3) "Complainant" or "grievant" is a parent, legal guardian, an authorized representative of the parent or legal guardian or a child whose disability of nonage has been removed who submits a complaint or grievance on behalf of an applicant, enrollee or former enrollee of the Florida KidCare Program. If a parent, legal guardian or a child whose disability of nonage has been removed appoints a representative to discuss the complaint or grievance on their behalf, they must complete and sign an Appointment of Representation Form, AHCA Med-Serv Form 017, August 2007, one page, and the Authorization for the Use and Disclosure of Protected Health Information Form, AHCA Med-Serv Form 018, August 2007, two pages, which are incorporated by reference. These forms name the representative and give the representative access to medical records in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

(4) "Enrollee" means a child who has been determined eligible for and is receiving coverage under Sections 409.810-.820, F.S.

(5) "Grievance" means a formal written complaint initiated to challenge an eligibility or enrollment decision only after all other forms of resolution have been exhausted through the Florida KidCare Formal Dispute Review Process.

(6) "Health Services" means the medical and dental benefits provided by an individual's health care coverage (e.g., hospital services, physician services, prescription drugs and laboratory services).

Level One Dispute

(a) "Level One" initiates the informal dispute review for the Florida KidCare Dispute Review Process. The informal dispute review begins when a complainant calls a Florida KidCare customer service representative to discuss his or her dissatisfaction about an eligibility or enrollment decision. The initial contact can also be communicated in writing. The Florida KidCare customer service representative will attempt to clarify or resolve the dispute through the telephone conversation. If the complaint is resolved to the satisfaction of the complainant, no further action will be taken.

(b) If the Florida KidCare customer service representative determines that a dispute cannot be resolved through a telephone conversation, the Florida KidCare customer service representative shall request the complainant forward documentation concerning the dispute to the Florida Healthy Kids Corporation office within 90 calendar days of the date of the letter received indicating denial, suspension or termination of enrollment. All Florida Healthy Kids Corporation customer service representatives and the Florida Healthy Kids Corporation's Third Party Administrator representatives shall offer the complainant a dispute review form to assist them in filing a request for a dispute review. A dispute review form is not mandatory. The complainant can request to dictate to a resolution representative any information that is necessary to begin or supplement a formal dispute. During the dictation process, the complainant shall provide the following information to the resolution representative: complainant's name, address, family account number, home and work telephone number; names of the children involved in the dispute, an explanation of the dispute and the names of other agencies sent a formal dispute about this matter.

(c) A written or e-mail request to begin the formal dispute review process shall be sent by the complainant to the Resolution Coordinator. A request to begin the formal dispute process must be initiated by a parent, guardian, or another individual listed on the Florida KidCare account as the person authorized to discuss all details of the account.

(d) The Resolution Coordinator shall send written acknowledgement to the complainant within three (3) calendar days after the Florida Healthy Kids Corporation receives a written request to initiate the Florida KidCare Formal Dispute Review Process. The written notification will explain all remaining levels of the Florida KidCare Dispute Review process to the complainant.

(e) If the complainant requests continuation of enrollment pending the completion of the review, the Dispute Resolution staff shall take the following steps:

1. Determine whether the complainant requested the continuation of enrollment within ten (10) working days of the date of the letter indicating the suspension or termination of his or her child(ren)'s enrollment.

2. If the request was not made within ten (10) working days of the date of the letter the complainant received informing him or her of suspension or termination of his or her children's enrollment, the Florida Healthy Kids Corporation Dispute Resolution staff shall inform the complainant in writing of the denial of continuation of enrollment.

3. If the request was made within ten (10) working days of the date of the letter the complainant received informing him or her of suspension or termination of his or her child(ren)'s enrollment, the Florida Healthy Kids Corporation Dispute Resolution staff shall take the following action to ensure continuation of enrollment, if the child(ren) meets all other Florida KidCare Program qualifications:

   a. Instruct the Third Party Administrator to stop the cancellation of the account or, if the account has already been cancelled, re-open the account back to the first day of the month in which the request for continuation was received.

   b. If the dispute concerns an increase in the premium rate, the Third Party Administrator staff shall maintain the premium rate in effect prior to the notification of an increase.

(f) If the complainant's child(ren) receive continuation of enrollment pending the completion of the dispute review process, the complainant must be made aware of the following conditions:

1. All premium payments must be paid in a timely manner in order to maintain the coverage during the continuation period.

2. If the formal dispute review is resolved in favor of Florida KidCare and not the complainant, the complainant will be legally responsible for paying back all premiums and the costs of services rendered during the continuation period.

(g) Disputes which involve more than one Florida KidCare Program entity shall be immediately referred to the Florida KidCare Grievance Committee. The Resolution Coordinator shall send

written notification to the complainant within three (3) calendar days and copy the relevant Florida KidCare Programs regarding a referral to the Florida KidCare Grievance Committee.

(h) The Resolution Coordinator shall review the complaint and make a determination regarding the complaint. The Resolution Coordinator shall send written notification to the complainant regarding the Level One Dispute Review decision.

Level Two Dispute

Level Two – Florida KidCare Formal Dispute Review Process
The complainant can initiate the Level Two Formal Dispute Review Process verbally or in writing. The Resolution Coordinator shall send written notification to the complainant that the complaint has been forwarded to the Florida Healthy Kids Corporation Executive Director or a designee for review. The Resolution Coordinator shall also forward all pertinent review documents to the Florida Healthy Kids Corporation Executive Director or the designee, who shall render a decision regarding the request. The Florida Healthy Kids Corporation Executive Director or designee shall notify the complainant of the decision in writing within twenty (20) calendar days of the referral to the Level Two Formal Dispute Process.

Level Three Dispute

Level Three – Florida KidCare Review Panel
If the complainant is dissatisfied with the decision determined at Level Two of the Florida KidCare Formal Dispute Review Process, the complainant can send a written request to the Florida KidCare Dispute Review Panel to further review the dispute.

The Florida KidCare Dispute Review Panel shall schedule a dispute resolution hearing between the dispute review committee members and the complainant within thirty (30) calendar days from the date of the request. Florida Healthy Kids Corporation shall schedule a hearing in the complainant's county of residence. The hearing shall be professionally transcribed. The Florida Healthy Kids Corporation shall be responsible for providing the transcriber. The complainant can waive the right to appear at the hearing. If the complainant waives the right to appear in-person at the hearing, the hearing shall be conducted at the Florida Healthy Kids Corporation Offices in Tallahassee, Florida. Members of the Florida KidCare Dispute Review Panel may participate in either hearing via a telephone conference call.

- The Florida Healthy Kids Corporation Executive Director or designee shall consider all complainant requests for assistance and respond to each on a case-by-case basis (e.g.,

reimbursement for parking, requests for a translator, etc.).

- The Florida KidCare Dispute Review Panel shall consist of three (3) voting members appointed by the Florida Healthy Kids Corporation's Executive Director. The voting members shall consist of two (2) Florida Healthy Kids Corporation Board members chosen based on accessibility or availability for the dispute resolution hearing and one of these members shall serve as the Chair. A Consumer Representative shall be appointed from an entity that assists families with health care or eligibility issues. The Florida Healthy Kids Corporation Corporate Counsel or, if the Corporate Counsel is not available, the Florida Healthy Kids Corporation, General Counsel shall serve as an advisor to the Dispute Review Panel.

The following applies to the Dispute Resolution hearing:

1. The complainant shall be given an adequate opportunity to examine the contents of the Dispute Review file and all other relevant documents and records prior to the hearing. The complainant can request and receive a complete copy of the materials provided to the Dispute Review Panel members prior to the hearing at no charge.

2. The complainant can represent themselves at the hearing or be assisted by a representative.

3. Complainants shall provide the names of any additional attendees (and their affiliations) they would like to have present at the hearing to the Resolution Coordinator in advance to be added to the hearing agenda.

The Dispute Review Panel shall make a decision to approve or deny the complainant's dispute. The Resolution Coordinator shall notify the complainant of the Dispute Review Panel's decision in writing within ten (10) calendar days of the hearing.

Level Four Dispute

Level Four – Appeal to the Florida Healthy Kids Corporation Board
If the complainant is not satisfied with the Florida KidCare Dispute Review Panel's decision, the complainant can request a review of the decision by the Florida Healthy Kids Corporation Board of Directors at its next regularly scheduled meeting. The complainant must submit a written statement and supporting documentation with the record of the Dispute Review hearing. No verbal testimony will be considered. The Board of Directors shall take one of three actions:
1. Accept the Dispute Review Panel's decision. This acceptance will be considered final for this segment of the review process;

2. Modify the Dispute Review Panel's decision. All modifications will be considered final for this segment of the review process; or
3. Send the dispute back to the Dispute Review Panel for further review as specifically directed by the Board of Directors.

The Resolution Coordinator will prepare a final report comprising all information concerning the dispute review process to the Florida Healthy Kids Corporation Executive Director and Board of Directors. The Resolution Coordinator shall notify the complainant of the Florida Healthy Kids Corporation Board of Director's decision in writing within ten (10) calendar days of the Florida Healthy Kids Corporation Board meeting. The written notification from the Florida Healthy Kids Corporation Board regarding the Board's decision shall also notify the complainant of the Florida KidCare Grievance Process.

If a complainant is dissatisfied with the decision made at Level Four of the Florida KidCare Program Dispute Review and if the Florida KidCare Program Dispute Review Process has been completed, a grievance can be filed with the Florida KidCare Grievance Committee.

Florida KidCare Grievance Committee

The Florida KidCare Grievance Committee shall review and resolve grievances related to the Florida KidCare Program when all four levels of resolution through the Florida KidCare Dispute Review Process have been completed. Grievances involving more than one Florida KidCare Program will also be addressed by this committee. Grievances heard by the Florida KidCare Grievance Committee shall include eligibility and enrollment matters relating to Florida Healthy Kids, MediKids or the Children's Medical Services Network. See Appendix C for Florida KidCare Grievance Procedures.

Appendix C
Florida KidCare Grievance Procedures

Statement of Intent

The Florida KidCare Grievance Committee shall review and resolve grievances related to the Florida KidCare Program when all four levels of resolution through the Florida KidCare Dispute Review Process have been completed. Grievances involving more than one Florida KidCare Program will also be addressed by this committee. Grievances heard by the Florida KidCare Grievance Committee shall include eligibility and enrollment matters relating to Florida Healthy Kids, MediKids or the Children's Medical Services Network.

Section 409.818(3)(e), *Florida Statutes*, directs the Agency for Health Care Administration to:

> "Establish a mechanism for investigating and resolving complaints and grievances from program applicants, enrollees, and health benefits coverage providers, and maintain a record of complaints and confirmed problems. In the case of a child who is enrolled in a health maintenance organization, the agency must apply the provisions of s. 641.511 to address grievance reporting and resolution requirements."

To implement this provision, it is the intent of the Florida KidCare program that the procedures to provide remedies for complaints, problems and grievances be appropriate, timely and simple.

The grievance procedures will conform to section 409.821, F.S. with respect to confidentiality of information.

Florida KidCare Grievance Committee Members

1. The Florida KidCare Grievance Committee consists of one representative from each of the following Florida KidCare partners, appointed by their respective agency. The fifth representative shall be the Project Director (or designee) of the Florida Covering Kids and Family Coalition.
    - Agency for Health Care Administration (MediKids)
    - Department of Children and Family Services (Medicaid for Children)
    - Department of Health (Children's Medical Services Network)
    - Florida Healthy Kids Corporation (Healthy Kids)
    - A representative of the Florida Covering Kids and Family Coalition
2. The Agency for Health Care Administration's representative will serve as the committee chairperson. The committee members will elect a co-chair, who will serve as the chairperson in the absence of the Agency's representative.

3. The committee shall meet the second Monday of each month. The committee shall not meet if there are no pending grievances. Additional meetings to resolve a grievance will be scheduled, as needed. If further documentation is necessary for the committee to reach a decision, the complainant will be notified in writing. When a grievance decision is rendered by the committee, the complainant will be notified in writing within ten (10) calendar days.
4. All committee members are required to be present or participate by telephone conference call on grievance decisions. Grievance review documents will be provided to committee members prior to committee meetings. If a committee member is not available to attend the committee meeting, a designated representative authorized to vote on behalf of the respective agency may participate as a substitute member. Anyone requiring special accommodations to participate in the committee meetings is asked to advise the Florida KidCare Grievance Committee administrative staff one week in advance of the day of the scheduled committee meeting.
5. Staff from the Agency for Health Care Administration will serve as the administrative staff for the Florida KidCare Grievance Committee. The duties and responsibilities of the administrative staff include: evaluating the Florida KidCare Dispute Review procedures to determine if the complaint was properly resolved for each grievance presented for the committee's review; preparation of grievance committee correspondence and documents; preparation and distribution of grievance committee minutes; and provision of all necessary information, including the grievance committee's final decision to all contributing parties.
6. Unless otherwise specified, committee meetings will be held in Tallahassee at the Agency for Health Care Administration's Headquarters offices. It is not mandatory for the grievant to be a participant at the grievance meeting(s). The grievant or authorized representative may attend the grievance committee meeting(s) at their own expense. If it is inconvenient for the grievant or representative to travel to the grievance committee meeting, the Agency for Health Care Administration staff will arrange for the grievant to participate by telephone conference call from the area Medicaid office closest to the grievant's place of residence.

Description of the Grievance Process

(1) If the grievant is dissatisfied with the action taken by the Florida Healthy Kids Board of Directors during the Level Four process of the Florida KidCare Dispute Review process, the grievant can submit a written request for the Florida KidCare Grievance Committee to review the grievance. The grievant's written request must be submitted to the Agency for Health Care Administration within ten (10) calendar days of the date appearing on the Florida KidCare Dispute Review Level Four final decision notice. In the event a grievant is unable to submit a request in writing, assistance will be provided by the Agency for Health Care Administration staff. If the request is not received within ten (10) calendar days, the Florida KidCare Grievance Committee reserves the right to decline the request.

All grievances must be sent to:

Florida KidCare Grievance Committee
Bureau of Medicaid Services
2727 Mahan Drive, MS #20
Tallahassee, FL 32308.

(2) When the written grievance request is received, the Agency for Health Care Administration staff will send a letter of acknowledgement to the grievant explaining the procedures of the grievance process within five (5) calendar days of receipt of the request for a grievance. The acknowledgement letter will include: the Florida KidCare Formal Grievance Form, AHCA Med-Serv Form 009, August 2007, one page; an Appointment of Representation Form, AHCA Med-Serv Form 017, August 2007; and the Authorization for the Use and Disclosure of Protected Health Information Form, AHCA Med-Serv Form 018, August 2007 which are incorporated by reference. In the event a grievance is submitted by someone other than the custodial parent or legal guardian, the Agency for Health Care Administration staff shall require the custodial parent or legal guardian to complete the forms referenced in this paragraph.

(3) The Agency for Health Care Administration staff will review the grievance and determine if the Florida Healthy Kids Corporation used appropriate measures as outlined in this rule when conducting the Dispute Review Process. When necessary, the relevant Florida KidCare partner of coverage will be contacted and asked to provide information associated with the case. If the initial eligibility or enrollment decision is correct and the Florida Healthy Kids Corporation followed the dispute review process outlined in this rule, the complainant will be notified in writing within five (5) calendar days of the Agency receiving the completed and executed forms referenced in subsection 59G-14.006(2), F.A.C., of this rule, that the decision determined during the Florida KidCare Dispute Review Process shall remain unchanged.

(4) If it is determined that further remedy is warranted, the committee shall be required to hear the grievance. The committee shall discuss the grievance at its next regularly scheduled monthly meeting.

(5) The committee members will review all pertinent information prior to the scheduled meeting. During the scheduled meeting the committee members will discuss and assess the grievance and any supplemental information provided. The following considerations apply to the Florida Grievance Review Process:

(a) The grievant shall be given an adequate opportunity to examine the contents of the Florida KidCare Dispute Review file and all other relevant documents and records prior to the Florida KidCare Grievance Committee meeting. The grievant can request and receive a complete copy of the materials provided to the Florida KidCare Grievance Committee prior to

the meeting at no charge.

(b) The grievant can represent themselves at the grievance meeting or be assisted by an authorized representative.

(c) The grievant shall be asked to provide the names and affiliations of any additional attendees he or she would like to have present during the grievance meeting prior to the scheduled grievance meeting.

(6) The committee members will verbally vote to render a decision. The committee's decision shall be based on a majority vote. The decision of the committee is final and all KidCare partners will abide by such decision. The grievant will be notified in writing of the committee's decision within ten (10) calendar days of the Florida KidCare Grievance Committee meeting.

Issues Not Subject to Committee Review

The Florida KidCare Grievance Committee will hear grievances for which no other vehicle of remedy exists. Grievances heard by the committee shall include eligibility issues relating to Healthy Kids, MediKids or the Children's Medical Services Network. Grievances involving more that one KidCare program will be addressed by this committee. Complaints, problems or grievances associated with the following issues will not be heard by the Florida KidCare Grievance Committee:

- *Quality of care*. When contacted with quality of care complaints, problems or grievances, the Florida KidCare partners will make appropriate referrals to existing mechanisms to address these issues.

  Florida Healthy Kids Corporation – The Resolution Coordinator shall contact the health services provider and request that the health services provider accept the complainant's written request to Florida Healthy Kids Corporation regarding a dispute as the initial step in the health services provider's dispute review process. With the complainant's consent, the Resolution Coordinator will forward any pertinent information to the health services provider. The Resolution Coordinator shall request the health services provider to respond to the complainant's dispute request in accordance with the time frames stated in its complaint or grievance process and 42 CFR s. 457.1160. The Resolution Coordinator shall follow up with the health services provider within twenty (20) calendar days of receipt of the complainant's dispute request to confirm appropriate action has been taken. The health services provider's action shall be documented including the date and time any action was taken.

  MediKids – The MediKids policy staff will refer the complainant to the appropriate health care provider for resolution of the dispute; or if the complainant requests, the MediKids policy staff will make a referral to the appropriate health care provider. When the complainant's child(ren) is enrolled in a managed care organization, the complainant will be referred to the managed care organization for resolution of the dispute. The MediKids staff shall request the

health services provider respond to the complainant's dispute request in accordance with the time frames stated in the provider's complaint or grievance process and 42 CFR s. 457.1160.

Children's Medical Services Network – A complaint may be made to the CMS area office or to the CMS Integrated Care System. For appeals of an action, the Integrated Care System handles the appeals process. If dissatisfied with the appeal decision, the CMS Network Statewide Grievance Panel is available to review the appeal decision. The panel makes a recommendation to the Deputy State Health Officer for Children's Medical Services to accept or modify the appeal decision. The decision of the Deputy State Health Officer for Children's Medical Services is final for all health service issues. The CMS Network complies with the requirements and time frames stated in 42 CFR s. 457.1160.

- *Benefits disputes*. Each Florida KidCare partner is responsible for resolving disputes about benefits relating to its own program.
- *Medicaid eligibility issues*. All decisions made by the Department of Children and Families with respect to Medicaid eligibility are final and may not be appealed beyond the Department's own fair hearing process.

Appendix D
Healthy Kids Dental Prior Authorization Process

Florida Healthy Kids Corporation contracts with two statewide dental plans to offer dental services to Healthy Kids enrollees. Healthy Kids does not have an annual dental benefit limit; however, the two dental plans require some services to be prior authorized by the plan.

The prior authorization requirements are not based on the dollar value of a service but are for designated specialty services or for services that tend to be over-used, abused or need special oversight or care management by the plan. There is an exception process in place by both contracted plans for emergency situations. The codes designated for prior authorization are reviewed and approved as part of Healthy Kids contracting process.

Florida Healthy Kids Corporation requires that all prior authorizations processes must be completed within fourteen (14) days of request by an enrollee for that service.

The Healthy Kids dental plans have very similar guidelines for their prior authorization process. For the purpose of Appendix D, the guidelines have been combined to provide a general overview of the codes and procedures requiring prior authorization and the conditions that may be required for referrals to specialty dentists. The following guidelines in its entirety, therefore, may or may not be required by both of the dental plans.

GENERAL DENTISTRY GUIDELINES

The Healthy Kids dental plans may require prior authorizations for the following American Dental Association (ADA) Codes or may be reviewed after the dental treatment has been performed. The common practice is to always obtain a prior authorization, but a post authorization is acceptable. Post authorizations are usually limited to emergency or urgent care, when a wait for prior authorization would be detrimental to the child. If services are provided without a prior authorization, the provider can submit the claim for payment, and the claim will be reviewed for medical necessity. The claim will not pay if the authorization is denied for not meeting the medical necessity criteria. Providers do have the option to perform services without prior authorization, and submitting retrospectively.

- Codes beginning with D27 and D29, crowns requiring radiographs
- Codes 3310, 3320, 3330 root canals requiring radiographs
- Codes 4341, 4342, periodontal scaling and root planing requiring radiographs and perio chart
- Code 4355, gross debridement requiring radiographs and narrative
- Codes 5110, 5120, complete dentures requiring radiographs
- Codes 5211, 5212, 5213, 5214, partial dentures requiring radiographs

- Codes beginning with D62, D67, fixed bridges requiring radiographs
- Codes beginning with D7220-D7999, soft tissue impactions and other oral surgery procedures requiring radiographs and narrative
- Codes beginning with D73, alveoloplasty requiring radiographs and narrative
- Codes 7510, 7511, incision and drainage of an abscess (will not be considered on the same date with extraction of tooth related to the I&D) requiring radiographs and narrative

Endodontic Guidelines

- Code 2950, core buildups, including pins
- Code 2954, prefabricated post and cores
- Code 3310, anterior routine endodontic therapy
- Code 3320, bicuspid endodontic therapy
- Code 3330, molar endodontic therapy
- Code 3220, therapeutic pulpotomy
- Code 3221, pulpal debridement on primary and permanent teeth
- Code 3230, pupal therapy on primary anterior teeth (resorbable filling)
- Code 3240, pupal therapy on primary teeth (resorbable filling)

To refer to an Endodontic, preoperative radiographs are required for the following cases:

- Code 3310, anterior endodontic therapy
- Code 3320, bicuspid endodontic therapy
- Code 3330, molar endodontic therapy
- Codes 3346, 3347, 3348, retreatment of previous endodontic therapy
- Codes 3351, 3352, 3353, apexification procedures
- Code 3410, anterior apicoectomy
- Teeth with existing crowns and bridgework
- Teeth with atypical root morphology
- Teeth with dilacerarted roots
- Teeth with calcified canals or root perforations

**Request for referrals for teeth with poor or guarded prognosis may result in a denial*
Endodontic Therapy Requirements:

- Pre-authorization is required for all endodontic treatment.
- Preoperative radiographs must be submitted with the pre-authorization.

- Claims submitted for emergency services rendered without pre-authorization must be submitted with pre and post operative radiographs.
- Claims for intraoperative and postoperative radiographs will not be reimbursed. These will be considered inclusive with the treatment codes for endodontic procedures.

Periodontal Guidelines

Periodontal care must be approved by the plan prior to periodontal services being rendered.
Pre-authorization for Periodontal treatment requires the following documentation:

- Completed and signed Pre-Authorization Request form
- Diagnosis including the periodontal disease classification
- Mounted full mouth series of radiographs
- Periodontal charting
- Intra-oral pictures when submitting for codes 4210 and 4211
- Narrative

**Periodontal scaling and root planing is the responsibility of the general dentist.*
Approval from the plan is also required for referrals to a Periodonist with documentation indicated and listed above for the following:

- Codes 4210, 4211, gingivectomy and/or gingivoplasty.
- Codes 4240, 4241, gingival flap procedures.
- Codes 4260, 4261, osseous surgery.

Pedodonist Guidelines

A referral is required to a Pedodontist if a General Dentist is not able to see a child for behavioral management issues or any other issue expressed by the General Dentist. The plan will review and approve requests for referrals. An approval of the authorization must be obtained prior to the Pedodonist providing services.
The plan requires submission of pre-authorization for everything except:

- Exams, x-rays, fillings, cleanings and sealants

Orthodontic Guidelines

Orthodontic services are limited to those circumstances where the member's condition creates a medical disability and impairment to their overall physical development, as defined in the Florida Medicaid Dental Services Coverage and Limitation Handbook.
Referrals for Orthodontic Services
All orthodontic referrals must be approved prior to orthodontic consultation being provided.
Pre-authorization for Orthodontic services requires the following documentation:

- Completed and signed Pre-Authorization Request form
- Clinical photographs (prints or slides) showing:
    - Frontal view, relaxed, teeth in occlusion;
    - Profile, right or left;
    - Intraoral, right or left sides, teeth in occlusion;
    - Intraoral, frontal, teeth in occlusion; and
    - Occlusal view (if photos are submitted without complete records);
- Measurement of overbite and overjet;
- Panoramic or full mouth intraoral radiographs;
- Lateral cephalometric radiograph; and
- Trimmed models; articulated or "rough-trimmed" models should indicate the proper occlusion, either with lines or a wax bite. Models that are unable to be articulated or are too damaged in shipping will not be evaluated.

Oral Surgery Guidelines

Uncomplicated extractions, removal of soft tissue impactions or minor surgical procedures are considered basic services and are the responsibility of the general dentist. The member may be referred to a contracted plan oral surgeon when it is beyond the scope of the general dentist.

All referrals to an oral surgeon must be pre-approved by the plan prior to services being rendered.

To approve a pre-authorization for a member to a contracted plan oral surgeon the member must have the following conditions:

- Third molar impactions
- Severely dilacerated roots
- A tooth broken below the bone level
- Roots or roots apex in the sinus
- Pain and/or swelling around the affected area

For approval for an oral surgeon pre-authorization for third molar extractions the following criteria must be met:

- Internal or external resorption
- Dentigerous cyst
- Periodontal disease in connection with an adjacent third molar
- Pathology involving the third molar

- Recurrent pericoronitis
- Non-restorable carious lesion
- Any potential future damage to the adjacent tooth

The following codes and documentation are required for approval:

- Codes 7210, 7220, surgical removal of erupted tooth, radiographs and narrative.
- Codes 7230, 7240, 7241, surgical removal of impacted teeth, radiographs and narrative.
- Code 7250, surgical removal of residual roots, radiographs and narrative.
- Code 7280, surgical access of unerupted tooth, radiographs and narrative.
- Codes 7310, 7311, 7320, 7321, alveoplasty in conjunction with extraction, radiographs and narrative.
- Codes 7510, 7511, incision and drainage of abscess, radiographs and narrative. (Will not be considered on the same date with extraction of tooth related to the incision and drainage)

Emergency pre-authorization requests for oral surgery procedures should not exceed two teeth per pre-authorization requests. Exceptions are made on a case by case basis.

Guidelines for the Pediatric Dentist

- Pediatric Dentists have open access to see plan members from ages 0 – 8.
- Children from ages 9 – 12 will need a referral from a General Dentist.
- New patients and patients of record ages 13 and older will need to be seen by a General Dentist. Any referrals for children ages 13 and older will be handled on a case by case basis.

It is the responsibility of the pediatric dentist to obtain preauthorization for any of the following procedures:

Procedure Code	Description
1510	space maintainer – fixed – unilateral
1515	space maintainer – fixed- bilateral
2930	stainless steel crown – primary tooth
2931	stainless steel crown – permanent tooth
2932	resin crown
3220	therapeutic pulpotomy
3221	pulpal debridement
3230 & 3240	pulpal therapy – resorbable filling
4341	periodontal scaling & root planing
4342	periodontal scaling & root planing

4355	full mouth debridement
7210, 7220	surgical removal of erupted tooth
7230, 7240, 7241	surgical removal of impacted teeth
7510, 7511	incision & drainage of abscess

Hospital Case Management
All non-emergency hospital cases require a preauthorization. Only cases with the following conditions will be considered:

- Medically compromised patients
- Severe behavior management cases
- Complex restorative cases

Criteria for Medical Immobilization including Papoose Boards (ADA code 9920)
Written and signed informed consent from a legal guardian is required and needs to be documented in the patient record prior to this procedure. The specific nature of the recipient management problem and the technique utilized must be documented in writing in the recipient's dental record.

Techniques acceptable for 9920 include:

1. Papoose or Pedi-wrap
2. Two or more personnel to assure safety of child and staff.

Techniques not acceptable for 9920 include:

1. Tell-show-do
2. Positive reinforcement or abnormal amount of time consumed.

Routine use of restraining devices to immobilize young children in order to complete their dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.

The plan will not reimburse for behavior management if:

1. Billed routinely every time the recipient visits the office; or
2. Billed with either sedation or analgesia on the same date of service.

Indications for behavior management include patients who require immediate diagnosis and/or limited treatment and cannot cooperate due to a mental or physical disability.

Please note the following:

- Dentist must not restrain children without formal training in medical immobilization.
- Dentist auxiliaries must not use restraining devices to immobilize children.

Appendix E
Dependents of State Employee Coverage
Maintenance of Agency Contribution

The charts below show the total monthly and annual premium for career service and payall state employee family coverage, broken out by the family's premium and the state's expenditure. The Consumer Price Index for medical expenses (CPI-Medical) rate is shown for each year and the inflation column represents the previous year's state expenditure multiplied by the CPI-Medical for that year. The result is the last column entitled "1997 Annual State Expenditure Increased by CPI". In order to meet the maintenance of agency contribution requirement to cover state employees using Title XXI funding, the actual state expenditures need to exceed the annual state expenditure increased by the CPI. The charts below show that the State of Florida meets the maintenance of agency contribution requirement with the state annual expenditure exceeding the annual state expenditure increased by the CPI for each year since 1997. Going forward, each year will be computed to ensure continued compliance with the maintenance of agency contribution requirement.

Career Service State Employees									
Year	State Employee Health Insurance			State Employee Health Insurance			CPI-Medical	Inflation	1997 Annual State Expenditure Increased by CPI
	Total Family Monthly Premium	Employee Monthly Family Premium	State Monthly Expenditure	Total Family Annual Premium	Employee Annual Family Premium	State Annual Expenditure			
1997	$361.72	$93.58	$268.14	$4,340.64	$1,122.96	**$3,217.68**			**$3,217.68**
1998	$456.20	$93.58	$362.62	$5,474.40	$1,122.96	**$4,351.44**	3.2%	$102.97	**$3,320.65**
1999	$470.23	$107.61	$362.62	$5,642.76	$1,291.32	**$4,351.44**	3.5%	$116.22	**$3,436.87**
2000	$507.80	$116.20	$391.60	$6,093.60	$1,394.40	**$4,699.20**	4.1%	$140.91	**$3,577.78**
2001	$583.96	$133.62	$450.34	$7,007.52	$1,394.00	**$4,699.00**	4.6%	$164.58	**$3,742.36**
2002	$659.83	$151.00	$508.83	$7,918.00	$1,812.00	**$6,106.00**	4.7%	$175.89	**$3,918.25**
2003	$765.50	$175.17	$590.33	$9,186.00	$2,102.00	**$7,084.00**	4.0%	$156.73	**$4,074.98**
2004	$842.00	$175.17	$666.83	$10,104.00	$2,102.00	**$8,002.00**	4.4%	$179.30	**$4,254.28**
2005	$895.92	$180.00	$715.92	$10,751.00	$2,160.00	**$8,591.00**	4.2%	$178.68	**$4,432.96**
2006	$967.58	$180.00	$787.58	$11,611.00	$2,160.00	**$9,451.00**	4.0%	$177.32	**$4,610.28**
2007	$1,016.00	$180.00	$836.00	$12,192.00	$2,160.00	**$10,032.00**	4.4%	$202.85	**$4,813.13**
2008	$1,127.75	$180.00	$947.75	$13,533.00	$2,160.00	**$11,373.00**	3.7%	$178.09	**$4,991.21**
2009	$1,127.75	$180.00	$947.75	$13,533.00	$2,160.00	**$11,373.00**	3.2%	$159.72	**$5,150.93**
2010	$1,184.14	$180.00	$1,004.14	$14,209.68	$2,160.00	**$12,050.00**	3.4%	$175.13	**$5,326.06**
2011	$1,243.34	$180.00	$1,063.34	$14,920.08	$2,160.00	**$12,760.00**	3.0%	$159.78	**$5,485.85**
2012	$1,243.34	$180.00	$1,063.34	$14,920.08	$2,160.00	**$12,760.00**			

Payall State Employees									
Year	State Employee Health Insurance			State Employee Health Insurance			CPI-Medical	Inflation	1997 Annual State Expenditure Increased by CPI
	Total Family Monthly Premium	Employee Monthly Family Premium	State Monthly Expenditure	Total Family Annual Premium	Employee Annual Family Premium	State Annual Expenditure			
1997	$361.72	$0.00	$268.14	$4,340.64	$0.00	**$4,340.64**			**$3,217.68**
1998	$456.20	$0.00	$362.62	$5,474.40	$0.00	**$5,474.40**	3.2%	$102.97	**$3,320.65**
1999	$470.23	$0.00	$362.62	$5,642.76	$0.00	**$5,642.76**	3.5%	$116.22	**$3,436.87**
2000	$507.80	$0.00	$391.60	$6,093.60	$0.00	**$6,093.60**	4.1%	$140.91	**$3,577.78**
2001	$583.96	$0.00	$450.34	$7,007.52	$0.00	**$7,007.52**	4.6%	$164.58	**$3,742.36**
2002	$508.83	$0.00	$508.83	$6,106.00	$0.00	**$6,106.00**	4.7%	$175.89	**$3,918.25**
2003	$590.33	$0.00	$590.33	$7,084.00	$0.00	**$7,084.00**	4.0%	$156.73	**$4,074.98**
2004	$666.83	$0.00	$666.83	$8,002.00	$0.00	**$8,002.00**	4.4%	$179.30	**$4,254.28**
2005	$715.92	$0.00	$715.92	$8,591.00	$0.00	**$8,591.00**	4.2%	$178.68	**$4,432.96**
2006	$787.58	$0.00	$787.58	$9,451.00	$0.00	**$9,451.00**	4.0%	$177.32	**$4,610.28**
2007	$836.00	$0.00	$836.00	$10,032.00	$0.00	**$10,032.00**	4.4%	$202.85	**$4,813.13**
2008	$947.75	$0.00	$947.75	$11,373.00	$0.00	**$11,373.00**	3.7%	$178.09	**$4,991.21**
2009	$1,127.75	$0.00	$947.75	$13,533.00	$0.00	**$13,533.00**	3.2%	$159.72	**$5,150.93**
2010	$1,184.14	$30.00	$1,004.14	$14,209.68	$360.00	**$13,849.68**	3.4%	$175.13	**$5,326.06**
2011	$1,243.34	$30.00	$1,063.34	$14,920.08	$360.00	**$14,560.08**	3.0%	$159.78	**$5,485.85**
2012	$1,243.34	$30.00	$1,063.34	$14,920.08	$360.00	**$14,560.08**			