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 #23
October 1, 2012

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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))**

Justin Senior, 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: Justin Senior 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 State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☒ A combination of both of the above.

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

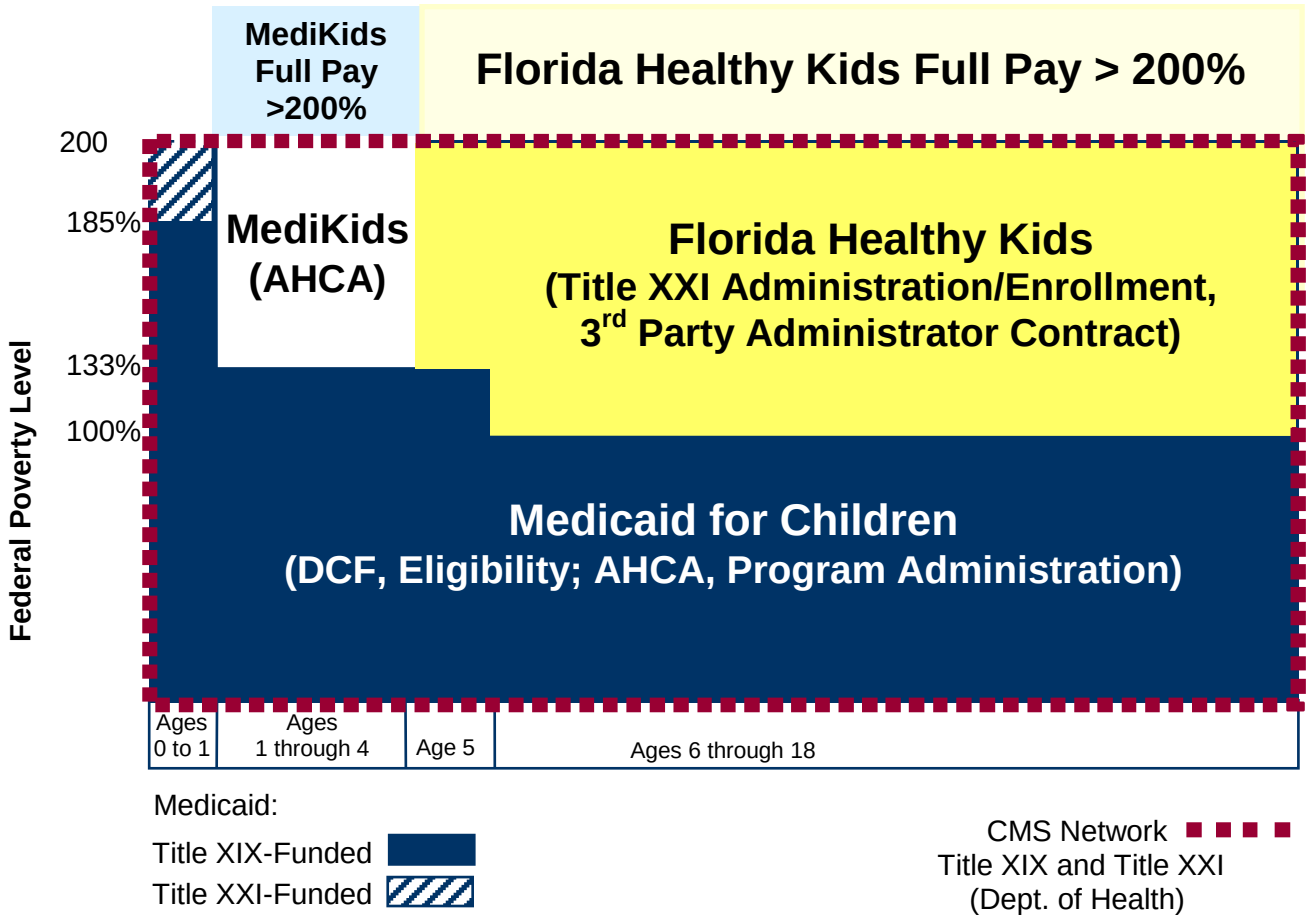
Phase 1 (*effective April 1, 1998*)

- 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.

Florida KidCare Eligibility



1.2 ☒ Please 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 ☒ Please 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)**

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

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

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

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 Miccousukee 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.

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

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). **(42 CFR 457.80(a))**

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*.

Part 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.

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 2 million Medicaid patients are children — about 1.3 million. Florida Medicaid covers children at the following income levels:

Florida Medicaid Child Eligibility		
Age	Federal Poverty Level	200912 Annual Income Family of 4
0 to 1	185% (Title XIX - effective 7/1/00)	$42,6432
0 to 1	185.01% - 200% (Title XXI Medicaid Expansion)	$46,100
1 to 6	133%	$30,657
6 to 15	100%	$23,050
15 to 19	100% (effective 4/1/98)	$23,050

Managed care is an integral part of the Florida Medicaid program. Medicaid beneficiaries have several types of managed care options available, including managed care organizations and MediPass, which is a primary care case management program. Children account for approximately two thirds (2/3) each of the populations eligible for MediPass and managed care organizations.

Florida has a strong historical commitment to Medicaid outreach. Since the late 1980s, the state has out stationed eligibility staff with major health care providers to make eligibility services more accessible. Out posted sites have included hospitals serving large numbers of Medicaid patients, county health departments and Regional Perinatal Intensive Care Centers. Currently, almost 254 eligibility specialists are out posted.

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 was part of a 17-member group of states working with the Southern Institute for Children and Families. The Institute received a grant from the Robert Wood Johnson Foundation to provide technical assistance, hold conferences, and prepare outreach materials to assist states in informing low-income families who may or may not be losing other public assistance eligibilities about other benefits that they may qualify for, including Title XIX or Title XXI benefits.

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.
- County health departments are MediPass providers for Medicaid patients. 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. Department of Children and Families' eligibility specialists are co-located at FHKC in Tallahassee.

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;

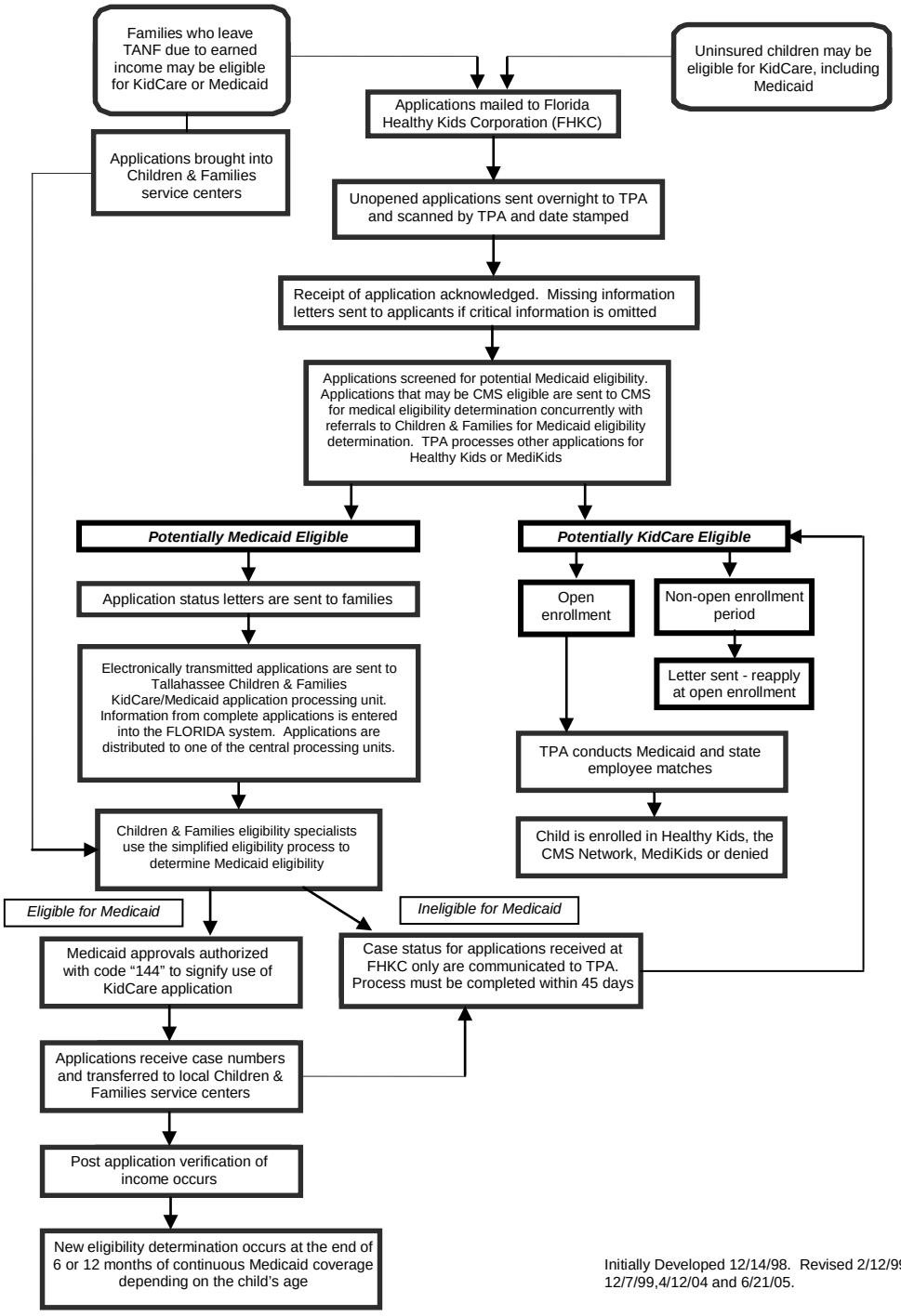
- collecting monthly premiums from Title XXI families in accordance with the fee schedule, distributing coupon books to families, sending follow-up letters to families who have not made their monthly premium payments, and disenrolling children whose families do not make their monthly premium payment;
- 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 or MediPass provider.
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.
	PIC Services: Title XXI PIC services is an extension of the Medicaid 1115 waiver which established PIC services as a coordinated effort between the Department of Health, chiefly CMSN, the Agency for Health Care Administration and Florida Hospices and Palliative Care, Inc. The same

criteria and referral process used in the 1115 waiver is used for Title XXI PIC services. After a child is determined eligible for Title XXI and enrolled in the CMSN, if the child meets the criteria for PIC services and the family chooses to receive PIC services, CMSN refers the child to hospice to evaluate the need for PIC services. The PIC services become an overlay to the child's medical services. The CMSN care coordinator takes the lead in coordinating between hospice and CMSN. The CMSN care coordinator is responsible for developing and maintaining the child's care plan. The care coordinator works in collaboration with the hospice care coordinator, making sure all of the PIC services are included in the care plan and that all services are provided and coordinated.

Florida KidCare Application Process



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

Department of Children and Families

The Department of Children and Families has eligibility specialists out stationed at the Florida Healthy Kids Corporation (FHKC) and at three additional sites throughout the state. These specialists conduct Medicaid eligibility determinations on new applicants to the Florida KidCare program. The Department of Children and Families will also continue to conduct Medicaid eligibility determinations in its district offices .

Families will have two ways to apply for Medicaid for their children: (1) using the traditional "Request for Assistance" form and process, or (2) using the Florida KidCare application.

Request for Financial Assistance Application	A family who chooses to apply for Medicaid for their children and other benefits, such as cash assistance, food stamps, and Medicaid eligibility for parents and other adults, will use the "Request for Financial Assistance" application form. Families who apply for multiple benefits will continue to make their applications through the local Department of Children and Families district offices.
Florida KidCare Application	A family who chooses to apply for children's health insurance only, may complete the Florida KidCare application at the local Department of Children and Families district office. During an open enrollment period, the Florida KidCare application can also be mailed to FHKC in Tallahassee for processing.

If a child is determined Medicaid eligible based on the Florida KidCare application or the Request for Financial Assistance application, the child will be enrolled in Medicaid. If the child is not Medicaid-eligible, the information is electronically transmitted to FHKC for Title XXI processing.

The Department of Children and Families has modified its "loss of Medicaid eligibility" letters to families to inform them about the Florida KidCare program.

Children's Medical Services Network and Children's Mental Health Services

Medical eligibility criteria for the CMSN include chronic physical and developmental conditions, and serious emotional disturbances, as identified by the Department of Children and Families, Children's Mental Health program. Children enrolled in the CMSN will receive the same benefits as those offered through the Medicaid program.

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.

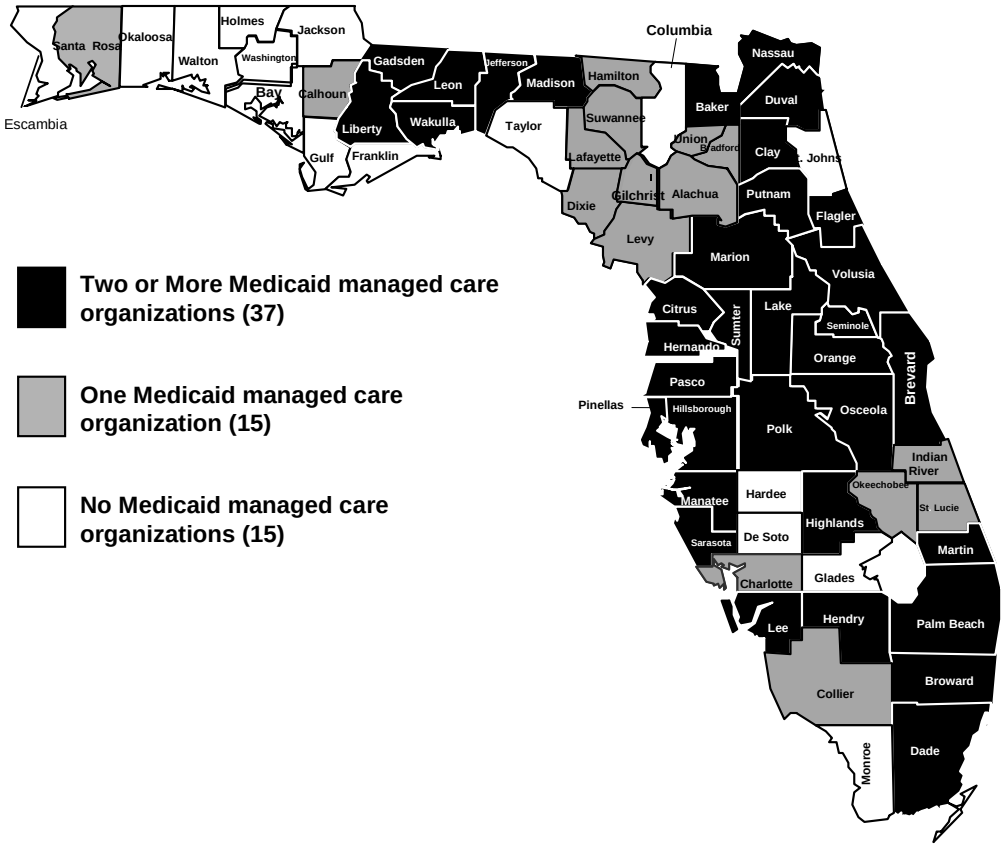
The two federally recognized tribes in Florida are the Seminole and Miccosukee tribes. A letter was sent to each tribe on August 15, 2011, suggesting a consultation process for Title XXI State Plan Amendment changes. The suggested process includes sending a letter to each tribe 30 days in advance of 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.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and 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) (42CFR 457.490(a))**

Florida Medicaid/MediKids Managed Care Organizations Coverage



MediKids

MediKids children are enrolled in Medicaid managed care plans and MediPass, a primary care case management program. MediKids children have the following choices:

- In counties with no managed care plans, the family can select a MediPass primary care provider.
- In counties with one managed care plan, they also have the choice of selecting a MediPass primary care provider.
- In counties with two or more managed care plans, the child must be enrolled in one of the managed care plans.

The managed care plan or MediPass provider will provide the same services to a MediKids-enrolled child that a Medicaid-enrolled child receives, except for Medicaid waiver services (e.g., AIDS waiver, and other home and community-based services waivers).

State law explicitly prohibits MediKids from providing interim benefits to a MediKids-eligible child until the child is officially enrolled in a managed care organization or MediPass. Therefore, since the managed care plan selection is part of the eligibility process it is vital that families make a choice as quickly as possible. In order to expedite this part of the eligibility process, the Agency for Health Care Administration sends a letter to the family advising them of their health plan choices. The letter advises them that a choice has been made for them, but that they can call the MediKids Helpline to discuss their options and change managed care plans. If their child is approved for MediKids, they will be assigned to their selected health plan when coverage begins. MediKids children also have the option of changing managed care plans at any time, since they are not subject to a lock-in period

Children under age one in the Medicaid expansion population are not part of the MediKids program, therefore, this policy does not apply to them. The Medicaid expansion children are treated like Medicaid, and the plan selection is made after coverage begins.

Healthy Kids

FHKC contracts with commercially licensed health and dental plans. These plans are selected through a competitive bid process conducted by FHKC. Beginning in 2004, FHKC was required to contract in the most cost-effective manner consistent with the delivery of quality medical care. Previously, the contracting guidelines required FHKC to select plans based primarily on quality criteria.

As part of the bid process, bidding insurers must submit a breakdown of the cost of the monthly premium by benefit categories, such as primary care physician office visits, specialist visits, inpatient care and pharmacy. The insurance rates are filed with the Office of Insurance Regulation at the Florida Department of Financial Services.

The 2003 Florida Legislature prescribed in statute a minimum medical loss ratio and a maximum administrative cost for insurer contracts under Healthy Kids. The maximum medical loss ratio is 85% and the maximum administrative component of any premium rate is 15%.

The state's largest inpatient safety net providers (Jackson Memorial Hospital, Shands Teaching Hospital, Tampa General Hospital, Miami Children's Hospital and All Children's Hospital) are also providers for many of FHKC health plans.

Initially, , Healthy Kids' enrollees were enrolled into the single participating provider in their particular county. In the more urban counties, Healthy Kids did provide families with a choice of plans. Families made their selection upon enrollment and then were locked into this plan until the annual choice period that usually occurs each year in the late summer. Additionally, effective October 1, 2003, the co-payments for certain health care services under Healthy Kids were increased from $3 to $5 per service.

To comply with CHIPRA, Healthy Kids also made a number of other changes to its managed care operations. These changes included the expansion of its good cause reasons to change plans outside of an enrollee's annual choice opportunity. The revised policy was posted for public comment before adoption. The current policy is posted on the Healthy Kids website.

Expanding the choice of health plans statewide was completed in June 2011. Now, Healthy Kids enrollees have a choice of at least two health plans in all 67 counties.

Additionally, the 2000 Florida Legislature directed the Florida Healthy Kids Corporation to implement a comprehensive dental program in certain counties. Initially, state funds were appropriated for the enrollment of up to 160,000 children into this program and the Corporation was given until June 30, 2002 to complete its implementation. For the first year, only those counties that provided a minimum of $4,000 in local matching funds were eligible for implementation of the program.

In the fall of 2000, Healthy Kids conducted a competitive bid process for a licensed dental insurer to provide services for children in eligible counties. The benefits mirror those offered to children enrolled in Florida's Medicaid program and families had the ability to choose from among three insurers.

The 2001 Florida Legislature removed the local match requirement for the dental

program and Healthy Kids began expanding the benefit on a statewide basis. As of June 1, 2002, the comprehensive dental benefit was available in 67 Florida counties.

As a result of legislation adopted by the 2003 Legislature, the dental benefit for the Healthy Kids program was modified. While the whole array of Medicaid dental benefits for children will still be available to Healthy Kids enrollees, an annual benefit cap of $750 per child per year was implemented effective July 1, 2003 through June 30, 2004. The benefit level was reduced to $600 effective July 1, 2004 through December 31, 2005 when the 2004 Legislature capped the dental premium rate to $12 per member per month. However, with the re-bid of the dental insurer contracts, the annual benefit cap was raised to $800 per member effective January 1, 2005. The $12 per member per month premium rate maximum remained in effect through June 30, 2006.

Effective July 1, 2009, contracts with four (4) statewide dental plans were executed and the dental benefit maximum was increased to $1,000 per year (measured July 1st through June 30th each year).

Effective July 1, 2010, Florida Healthy Kids Corporation contracted with two (2) statewide dental plans and eliminated the annual dental benefit limit to comply with CHIPRA legislation.

Children's Medical Services

The CMSN providers are the same providers as those who serve Medicaid children under the MediPass option for children with special health care needs. CMSN contracts with providers to offer a full range of services for these children. Families are offered a choice of primary care providers in the network. The CMSN provides the standard Medicaid benefit package to its enrollees.

The specialty care providers are primarily Medicaid providers and meet additional credentialing criteria or standards to serve children with special health care needs. For example, CMSN only uses certain facilities to perform cardiac surgery on children with special health care needs. Those facilities are designated by CMSN based on the recommendations of a cardiac advisory panel. This panel is comprised of experts in the field of pediatric cardiology and designates facilities based on national and state standards.

Contract providers are required to submit encounter level data to the CMSN. The encounter level data are used to determine the reimbursement rates based on Medicaid fee schedules.

The Department of Children and Families contracts with local mental health providers to provide specialized behavioral health services for CMSN enrolled school-age children with serious emotional disturbance (mood, psychotic or anxiety disorders) or substance abuse problems, subject to the availability of enrollment slots. Children on the waiting list for an enrollment slot will be provided with the standard Medicaid behavioral health package through the CMSN until a slot becomes available. These children also receive their physical health care through the CMSN.

A child with a physical, developmental or behavioral special health care need, but who does not have a serious emotional disturbance or substance abuse problem, will receive the standard Medicaid benefit package including the behavioral health services package through the CMSN.

Department of Health Comprehensive and Full Service School Health Services Initiative

Basic school health services are provided to all students in Florida public schools, and additionally, Comprehensive school health services and Full Service school health services are provided to low-income, at-risk school age children. Florida statute section 381.0056 requires that basic school health services be provided at all Florida public schools, including schools in the Comprehensive and Full Service School program. The Florida Department of Health's School Health Services Program promotes student health through prevention, screening, early intervention, and treatment or referral for acute or chronic health problems.

As required in Florida statute section 381.0057, , the Department of Health's Comprehensive School Health Services are available to locally determined schools in 46 Florida counties where there is a high incidence of medically underserved high-risk children, low birth weight babies, infant mortality, or teenage pregnancy. The purpose is to promote the health of students, reduce teenage pregnancy and other risk-taking behaviors, and facilitate the educational process in developing healthy, self-sufficient adults who will become productive citizens independent of public support. The program does this by focusing on prevention of high-risk behaviors, keeping children in school, healthy and ready to learn, and by facilitating early return of students who are out of school because of serious illness, or for childbirth and parenting. Sixty-six of Florida's sixty-seven counties provide Full Service School services per Florida statute section 402.3026. Full Service Schools are located in medically underserved, high-risk communities and they provide a range of health and social services (in addition to basic school health services) that increase access to health care and help to reduce health barriers to learning.

Target Populations
The Department of Health's Comprehensive and Full Service School Health Services Programs target 669,164 low-income, high-risk children in Kindergarten through 12th grade. In some of the schools with comprehensive or full service school programs, more than 70 percent of the students are on free or reduced lunch. Many of these students do not have health insurance.

Geographic Scope
In the most current year (2010) for which data is available, the Department of Health's Comprehensive School Health Services Program was available in 504 selected schools in 46 of the state's 67 counties. Full Service School Health Services were available in 413 schools spread across 66 counties.

Services Provided
During the school year, children spend many of their waking hours at school. Without comprehensive and full school health services, students with minor injuries, acute illness, chronic conditions, social and emotional issues may not be able to attend school. In the most current year (2010) for which data is available, , there were an estimated 14.2 million visits to school clinics across the state (estimated from clinic counts documented during February full-time equivalent (FTE) week) and more than 2.1 million doses of medication administered to school students. The school health nurse supports each student by implementing several strategies that promote student health and safety. Some of these strategies include:

- Providing direct health services and conducting screening, referral and clinical follow-up of suspected problems, including surveillance of high-risk behavioral health patterns, immunization status, diseases, and home and school safety practices;
- Medical supervision and coordination for pregnant and parenting students to assure that students have access and utilize needed services, home visits, helping students and families find willing and affordable providers, assisting with transportation to health care or in applying for children's health insurance programs such as Florida KidCare;
- Treating students for minor emergencies and acute illnesses;
- Provision of clinical intervention services, which includes school clinic care , nursing assessments, social interventions and services, and home visits;
- Providing health education within the school to reduce high-risk behaviors such as premature and unprotected sexual activity, smoking and other drug use,

driver/passenger safety, violence prevention, and to promote healthy life styles such as healthy nutrition and increased physical activity to prevent obesity and related chronic diseases;

- Identifying health and safety concerns in the school environment, and
- Administering medications.

In addition, Full Service Schools provide additional services, such as:

- Nutritional Services,
- Economic services,
- Job training,
- Parenting classes,
- Delinquency counseling,
- Counseling for abused children, and
- Mental health and substance abuse counseling.

Registered school nurses provide services that range from first aid, nursing assessment, health care planning and complex medical procedures to medication administration, health counseling, and health screening, referral and follow-up. They also provide case management to ensure that students access needed health and social services that enable them to remain in school or, in the case of pregnant and parenting students, return to school after delivery.

Health Care Providers

Services are provided by registered nurses, licensed practical nurses, , advanced registered nurse practitioners, social workers, and health asides who are trained to provide health services under the delegation and supervision of the registered nurses.. The services are provided in school, clinics, classrooms and collocated full service school service centers.

Funding Sources

Florida's Comprehensive and Full Service School Health Services programs are funded with state general revenue and additionally by Federal Title XXI dollars. In some counties, program participants have entered into partnerships with other public (such as county government) and private organizations. The programs do not receive any third-party insurance payments for services provided. A very small amount of Title XIX Medicaid funds, approximately $ 250,000 in calendar year 2010, have been billed for basic school health services under the County Health Department Certified Matching Program for school nursing services. This amounts to approximately 1% of

the DOH funding for School Health Services Programs in Florida. Full Service School Health Services expands the Health Services Initiative to 20 additional counties. These counties have always provided full-services school health services. Prior to July 1, 2011, no federal funding was used, as all funding for full service school health services was State funded from the Tobacco Settlement Trust Fund. Starting July 1, 2011, the Florida Legislature changed the appropriations so that full service school services would be funded by a combination of federal Title XXI and General Revenue funds.

Assurances

The state will not use federal funds as the state matching share for receipt of Title XXI funds for the Department of Health's Comprehensive School Health Services initiative. Only state funds or local funds will be used to meet the state matching requirement. This includes all school health tobacco settlement and general revenue funds. Health room records and state data coding will be used to document services provided and to ensure that the federal programs are billed correctly.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the 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) (42CFR 457.490(b))**

MediKids

MediKids will be subject to the same utilization controls as the traditional Medicaid program. Examples include peer review, data analysis for over- or under-utilization of services, application of InterQual criteria to appropriateness of inpatient hospital stays, and case file review for outpatient ambulatory care.

Healthy Kids

Healthy Kids receives on a quarterly basis health care utilization reports from all of its contracted health and dental plans that are analyzed by the University of Florida Institute for Child Health Policy (ICHP) and a schedule of special reports is agreed to between the FHKC and ICHP each year. The health plans also conduct internal utilization control programs.

As FHKC's external quality review organization, ICHP also conducts activities with the contracted health and dental plans that ensure that enrollees receive appropriate services. ICHP reports using the voluntary CHIPRA measurements and creates an annual Quality Chart Book of its findings by plan that highlights performances under

HEDIS, CAHPS and other standards. Plans not meeting performance standards established by FHKC are then engaged in Performance Improvement Projects (PIPs) which are also monitored by ICHP.

Additionally, FHKC has contracted with an independent medical quality auditor, also currently ICHP, who will review medical records as well as conduct site visits on a random sample of providers and assess appointment and network accessibility. The auditor's reports will be presented to a designated committee of the FHKC Board of Directors for any necessary action. Plans are reviewed annually for compliance with FHKC's appointment, access and credentialing standards.

Children's Medical Services Network

The CMSN uses the same utilization controls employed by the Healthy Kids Corporation. In addition, CMSN uses teams of health care professionals to determine the medical necessity for certain services such as private duty nursing and skilled nursing facilities.

Providers are expected to have internal and concurrent utilization management programs. In addition, CMSN is subjected to Medicaid's peer review organization and other Medicaid reviews for Medicaid children with special health care needs.

For specialized behavioral health benefits for SED children, the Department of Children and Families will use the same utilization controls that are currently in place to manage Medicaid mental health service utilization. Certain services (such as psychiatric hospitalization) will require pre-authorization. Other services will be reviewed on a selected basis for under- or over-utilization.

Claims Payment

The Children's Medical Services Network and MediKids comply with the provisions of 42 CFR 447.45 related to timely claims payment for its Title XXI population.

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 Familiy 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, the TPA, and the Florida State Employees Payroll System. Electronic matches are conducted on at least a monthly basis, if not more frequently, to identify the following conditions which may affect continued participation in the Florida KidCare program: (1) enrollment in Medicaid, and (2) the parent's employment with a state agency. 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. Starting April 1, 2006, all applications are matched weekly with the Florida State Employees Payroll System. This ensures that any child of a state employee will be identified before the eligibility determination is complete.

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

Phase 1 Effective Date: April 1, 1998
Revised: 1/26/98, 2/19/98, 3/3/98, 3/6/98
Phase 2 Effective Date: July 1, 1998
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, 10/1/12

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. Some Department of Children and Families' eligibility specialists are co-located at FHKC in Tallahassee and others are located in service offices throughout the state. 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. 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.

In the event that all or a portion of the state is declared a disaster area by the Governor or the Federal Emergency Management Agency (FEMA), the Florida Healthy Kids Corporation, in consultation with the Agency for Health Care Administration and the Department of Health, will have the option of extending the renewal grace period an additional 60 days for families in the affected areas.

The Agency for Health Care Administration will notify the Centers for Medicare and Medicaid Services in the event of a declared disaster and Florida's intent to implement this policy modification. The CMS notification will include the intent to modify the renewal process, the areas affected by the disaster and the effective dates of the policy modification.
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. Florida will also fully study and re-evaluate this policy at the end of 36 months.

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

Education programs such as Head Start and other subsidized child care organizations

Programs	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 (Section 2103)

☐ **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 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

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

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

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

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.)

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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☒ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 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.

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

6.1.4.1. ☒ Coverage the same as Medicaid State plan
Basket of Benefits for MediKids and for CMSN is the same as Medicaid.

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

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

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"

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 (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

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)) (42CFR 457.490)**

MediKids, CMSN (including children enrolled through the CMSN 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 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))**

Healthy Kids inpatient mental health benefits include 30 inpatient/residential days per contract year. If residential services are used then at least 10 days must be reserved for inpatient services. Effective October 1, 2009, the days limits have been removed from this benefit.

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)**

Healthy Kids: Outpatient behavioral health benefits are limited to 40 outpatient visits per contract year. Effective October 1, 2009, the visit limits have been removed from this benefit.

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))**

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.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**
Healthy Kids: Nursing services in Healthy Kids are limited to skilled nursing only.

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))**

Children enrolled in MediKids and the CMSN 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.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

Healthy Kids: Inpatient behavioral health services are limited to not more than 7 inpatient days per contract year for medical detoxification only and 30 residential days. Effective October 1, 2009, the day limits on inpatient and residential services have been removed.

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

Healthy Kids: Outpatient visits are limited to 40 outpatient days per contract year. Effective October 1, 2009, the visit limit on outpatient services has been removed.

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))**

Healthy Kids: Therapy services are limited to 24 treatment sessions within a 60-day period and are intended for short-term rehabilitation only.

6.2.23. ☒ 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.

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

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))**
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.

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. The dental plans' internal grievance process used for the Healthy Kids program is the same internal grievance process used for the plans' Medicaid population.

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.

MediPass providers must be credentialed in accordance with the MediPass program requirements.

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 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. The plan must assure that primary care physician services and referrals to specialty physicians are available on a timely basis, to comply with the following standards: urgent care - within one day; routine sick patient care - within one week; and well care - within one month. 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;
- 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. Requests for prior authorization are handled exactly the same as those for Medicaid participants.

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)**

8.1.1. ☒ YES

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

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.

For Healthy Kids enrollees with family incomes above 200% 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.

8.2.2. Deductibles:

None of the Florida KidCare components charge deductibles.

8.2.3. 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.

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	

8.3. 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.

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))**

8.5. 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 150% of the federal poverty level, or $240 for families with incomes above 150% 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.

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 requires Medicaid managed care organizations to report a subset of HEDIS effectiveness of care measures. The MediPass program also uses these measures for MediPass providers. The child-related requirements will be applied to the MediKids program. Examples include:

- Childhood and adolescent immunization status;
- Frequency of selected procedures (e.g., myringotomy, tonsillectomy);
- Appropriate ambulatory treatment for diabetes and asthma to prevent unnecessary hospitalizations and emergency room care; and

The Medicaid program also analyzes utilization of children's dental health services. Medicaid is represented on a statewide dental coordinating council that will review utilization of diagnostic and preventive services compared to all other dental procedures for children (e.g., restorative, endodontics, and oral surgery). This council will use its findings to measure providers' performance and the appropriateness of dental care rendered to children. Since MediKids enrollees will receive the same dental benefits as Medicaid beneficiaries, this information will also be available for the MediKids program.

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 – 2012 - 2013

	Federal Fiscal Year Costs
Enhanced FMAP rate	**70.66**
Benefit Costs	
Insurance payments	
Managed care	
per month rate $ 169.44 @ 3,181,944 eligibles	539,148,591
Fee for Service	0
Health Services Initiatives	0
Total Benefit Costs	**539,148,591**
(Offsetting beneficiary cost sharing payments)	33,144,496
Net Benefit Costs	**506,004,098**
Administration Costs	
Personnel	
General administration	9,292,904
Contractors/Brokers (e.g., enrollment contractors)	25,616,113
Claims Processing	
Outreach/marketing costs	1,200,000
Other (Full Service School Health Services)	16,537,477
Total Administration Costs	**52,646,494**
10% Administrative Cost Ceiling	56,222,678
Federal Share (multiplied by enh-FMAP rate)	357,542,496
State Share	148,461,602
TOTAL PROGRAM COSTS	**506,004,098**

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Note: Source of state share are:

General Revenue: $ 53,465,191

Tobacco Funds: $ 94,996,411

Assumptions: Dental

SFY 09/10 Healthy Kids per member per month: $11.10, $1,000 cap

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

Phase 1 Effective Date: April 1, 1998

Revised: 1/26/98, 2/19/98, 3/3/98, 3/6/98

Phase 2 Effective Date: July 1, 1998

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, 10/1/12

SFY11/12 Healthy Kids and MediKids health plan rate freeze

The policy change regarding provisional CHIP coverage in SPA #23 coverage has no discernible budget impact.

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 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)

  <u>For Issues Specific to Eligibility and/or Enrollment:</u>

  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. When the complainant's child(ren) is enrolled with a MediPass provider, the complainant will be referred to the Area Medicaid

office for assistance with the dispute process. 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 – The Children's Medical Services Network staff will refer health services complaints to the relevant Children's Medical Service area office Nursing Director. The Children's Medical Services Network staff shall request that the complainant's dispute request is completed in accordance with the 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**			