Florida Healthy Kids Corporation

Invitation to Negotiate 2011-04

Actuarial Services

October 7, 2011

I. Introduction

The Florida Healthy Kids Corporation ("FHKC") is a Florida non-profit corporation. It was established by the State of Florida in 1990 to demonstrate the concept of using school systems as a grouping mechanism for the purpose of providing comprehensive health insurance coverage for children. The Florida Healthy Kids Corporation Act can be found in section 624.91, Florida Statutes.

The Healthy Kids program is one (1) component of Florida's KidCare program which provides health insurance coverage to children through four (4) separate programs: Healthy Kids, Medikids, Children's Medical Services Network ("CMSN") and Medicaid for Children. Florida KidCare is Florida's Title XXI or state Children's Health Insurance Program ("CHIP") which was created in 1998, pursuant to sections 409.810 through 409.821, Florida Statutes. This procurement invitation document covers only the Healthy Kids program.

Terms used in this Invitation to Negotiate ("ITN") are defined in the same manner as in the standard Contract included in this ITN and incorporated by reference. References to "Respondents" and "Bidders" or "Vendor" refer to those Parties that will respond or intend to respond to this ITN.

FHKC is not subject to the State of Florida bid requirements and has established its own competitive process for vendor selection. All interested parties should respond to the procurement invitation as outlined below. FHKC reserves the right to establish mandatory guidelines for vendor selection and may reject any or all bids at its discretion. In addition, FHKC may establish minimum response standards at its sole discretion.

II. Scope of Invitation to Participate (ITN)

FHKC is soliciting proposals from interested parties for actuarial services. The organization or organizations selected under this procurement process may be responsible for conducting some or all of the activities described in this solicitation on either an on-going basis through a long-term contract or through short-term, project limited arrangements on an as needed bases when identified by FHKC.

Requested Actuarial Services

- Annual Review of health plan rate adjustment requests (plan submissions due April 1st for October 1st effective date)
- Annual Review of dental plan rate adjustment requests (plan submissions due January 1st for July 1st effective date)
- Review of plan experience adjustment submissions (plan submissions due April 15th for plan year ending September 30th)
- Review of proposed health and dental plan premium rates during procurements (March\April 2011 for health, Winter 2012 for dental (projected), as needed)
- Medical trend analysis, as needed (at least annually, more frequently as needed)
- Evaluating legislative proposals
- Ad Hoc Reports (as needed)
- Plan Benefit or Co-Payment modification analysis (as needed)

FHKC is soliciting proposals under this ITN from any qualified organizations that can provide any or all of the services designated above and that are not disqualified or otherwise de-barred from receiving any federal or state funds. Bidders may propose additional services that are not included in the list above if the Bidder feels that FHKC would benefit from such services.

FHKC expects to award at least one (1) Contract but reserves the right to award more than one (1) Contract should this be to the benefit of FHKC in its sole discretion. Bidders are not guaranteed any minimum level of services under this ITN and Bidders must be willing to work and coordinate efforts with other Bidders that may be awarded Contracts under this ITN.

The award of any Contracts under this ITN is contingent upon the availability of funds for the Program and this project.

The proposed effective date of any contract(s) issued under this ITN is February 1, 2012.

III. Procurement Process

A. Evaluation of Proposals

Proposals will be evaluated in a two (2) step process. First, proposals that do not offer the requested services, fail to meet the minimum requirements, or change the program's objectives will be disqualified in FHKC's sole discretion.

Proposals meeting these minimum qualifications will then be evaluated as to the services being proposed and the relative value of those services to the cost proposed.

Factors that are taken into consideration during this process include, but may not be limited to:

- Respondent's performance status with FHKC if a current vendor or if a previous vendor;
- Existing or previous litigation or regulatory action by or against the State of Florida or FHKC;
- Respondent is not de-barred or otherwise prohibited from contracting with FHKC, the State of Florida or from receiving federal or state funds;
- Reference checks conducted on Bidder's performance as a vendor for comparable Contracts;
- Respondent's current and recent financial status;
- Demonstration of knowledge and understanding of CHIP programs, the targeted populations and specifically, FHKC;
- Experience providing similar services to the same or comparable populations;
- Proposed work plan and services being offered compared to the objectives of the Program;
- Demonstrated ability to meet contract requirements in a timely manner; and,
- Competitiveness and value of cost proposal(s) and pricing approaches.

Proposals may be evaluated by a Committee of the Board of Directors or by a staff evaluation team. Personal interviews may be requested with any or all Respondents in FHKC's sole discretion. If scheduled, all interviews are conducted in Tallahassee, Florida and are scheduled by FHKC.

The scope and length of any such Personal Interviews will be set by FHKC. Any materials presented by Respondents at the Personal Interviews will be considered public records. Respondents should also be aware that all submissions (ex: proposals, personal interview materials) received during this ITN process, selection criteria, scoring system and results from this ITN will be available for inspection upon request after the ITN process has been concluded in accordance with Florida law.

Respondents are responsible for ensuring that all elements of their proposals are provided in an organized and concise fashion. FHKC is not

obligated to interpret any elements not clearly labeled or described. All elements are subject to public inspection following the conclusion of the ITN process. FHKC reserves the right to review and evaluate proposals as submitted without further input or clarification from the Respondent.

B. Calendar of Events

A proposed Calendar of Events has been established for this ITN process. This Calendar is subject to change by FHKC. Any changes to the timeline will be posted to the FHKC website at www.healthykids.org.

Event	**Date** (All Times are Eastern)
Final ITN Release Date	October 10, 2011
Letters of Intent Due to Issuing Officer *Mandatory with Cover Sheet*	Thursday, November 10, 2011
Question and Answer Period	October 10, 2011 – October 28, 2011
Final Answers Posted to Website	November 16, 2011
Proposal Deadline	Thursday, December 1, 2011 12:00 NOON
Personal Interview Period *(At FHKC's discretion)*	December 12, 2011 – December 16, 2011
Anticipated Award Date	January 2012 FHKC Board Meeting
Implementation Date	February 1, 2012

A recommendation on the selection of Vendor or Vendors will be made to the FHKC Board of Directors following the conclusion of the evaluation process. The FHKC Board of Directors shall determine the final award of any Contract or Contracts. Award announcements are anticipated at the January 2012 or later board meeting but are subject to change.

Any of the deadlines or dates may be modified in FHKC's sole discretion.

C. Single Point of Contact

Respondents to this ITN and their agents may only contact the Issuing Officer, Jennifer Kiser Lloyd, Chief External Affairs Officer at lloydj@healthykids.org, during this procurement process. If Respondents or their agents contact any other employee of FHKC, an FHKC Board Member or Committee member, including ad-hoc board members, regarding this ITN or this procurement process before the final Contract awards has been made by the FHKC Board of Directors, Respondent's proposal may be disqualified in the sole discretion of FHKC.

D. Questions Regarding the ITN

Any explanation desired by Respondents regarding the meaning or interpretation of the ITN must be submitted in writing to the Issuing Officer through one (1) of the following methods: faxed to (850) 224-0615 or submitted electronically to lloydj@healthykids.org; no phone calls will be accepted. Only those questions received in writing will receive a response. All questions will be posted to the website for all Respondents to view.

Questions will be accepted through November 4, 2011. All questions received by the deadline will be answered by November 16, 2011 and posted to the website. Questions received after the deadline will be considered on a case-by-case basis by FHKC for a determination as to whether or not all potential bidders would benefit from a response. Any responses will be posted to the FHKC website.

E. Requests for Supplemental Information

Written requests for any information not included with this ITN will be considered by FHKC. All attempts to satisfy reasonable requests for information will be made by FHKC. If FHKC determines that such information would be beneficial, the information will be posted on FHKC's website.

Once an ITN has been issued, individual public records requests for information relating to prior procurement processes and bid responses will be honored through the scheduling of a public viewing of such records. Grading tools and procurement files from prior processes are no indication of future processes.

Any information or responses received by interested parties verbally or through other representatives either before or during this ITN process are

not binding on FHKC, and Respondents should not rely on such information.

In accordance with state law, proposals received under this ITN, the grading tools and other materials developed as part of this process are not available to the public until the process has concluded.

F. Amendment of the ITN

FHKC reserves the right to amend any portion of the ITN at any time prior to the announcement of Contract award. In any such event, all Respondents will be afforded an opportunity to revise their proposals to address ONLY the amendment, if in FHKC's sole discretion, it determines such an amendment is necessary.

G. Special Note – Disclosure Statement

FHKC is a private, Florida non-profit corporation and not subject to the bid requirements of the State of Florida. FHKC may elect to consider or reject any or all responses. Information contained in any proposals received under this ITN is not available to any other respondents until the ITN process has been concluded. A Respondent's response to this ITN and the submission of any subsequent formal proposal or bid indicates its agreement to this statement.

IV. Other Terms and Conditions

A. Most Favorable Terms

FHKC reserves the right to award a Contract without any further discussion with the Respondents regarding the proposals received. FHKC reserves the right to contact individual Respondents to clarify any point regarding their proposals or to correct minor discrepancies. FHKC is not obligated to accept any proposal modification or revision after the bid submission date.

B. Withdrawal of Proposals

Respondents may withdraw any or all proposals at any time prior to execution of a Contract by submitting a written statement to the Issuing Officer.

C. Conditions

Proposals that contain conditions, caveats or contingencies for acceptance will not be considered and may be disqualified without further consideration or opportunity for modification or clarification by the Respondent.

All documents, data, products, graphics, computer programs, deliverables and reports prepared by the Respondent pursuant to any Contract or Agreement executed as a result of this ITN shall be considered property of FHKC upon payment for the product or services. All such items shall be delivered to FHKC at the completion of work or Contract, as determined by FHKC.

D. Competitive Negotiation Process

In the final phase of the ITN, FHKC may elect to enter into negotiations with selected Respondents in order to select the best Respondent or Respondents for the project.

FHKC also may elect to execute a Contract or Contracts with a selected Respondent or Respondents without any further negotiation. Therefore, proposals should be submitted in complete form, and pursuant to all terms and conditions as required in this ITN.

FHKC is the sole judge of which proposals provide the best solutions in terms of technical merits and price.

E. Announcements and Press Releases

Any announcements or press releases regarding Contracts awarded under this ITN must be approved by FHKC prior to release.

V. Submission Requirements

A. Submission Address and Deadlines

In order to be considered, all proposals must be submitted to the Issuing Officer at the address listed below in the manner prescribed under this ITN:

Jennifer Kiser Lloyd
Chief External Affairs Officer
Florida Healthy Kids Corporation
661 East Jefferson Street
Florida Bar Annex Building, 2nd Floor
Tallahassee, Florida 32301
(850) 701-6108

Respondents should thoroughly address all of the stated components for each designated lettered Tab. The Respondent should consult the ITN and associated documents, and the proposed Contract for additional information or guidance on each of the proposal components.

Proposals must be received by **12:00 noon (Eastern) on December 1, 2011.** Proposals received after this date and time will NOT be considered.

B. Specific Contents

Each proposal must be presented in hard copy format (three-ring binders that are easily flip-able) and electronic format (searchable CD) in the following manner:

- ✓ Each notebook and CD must be clearly marked with the Respondent's official and legal name, address and contact information in the front of each notebook and on each CD cover.
- ✓ Information contained on the CD must be in WORD format.
- ✓ Within the response, both electronic and hard copy, the contents should be organized by lettered and numbered tabs as designated below.

Tab A: Profile of Respondent

Tab 1:

Background information and corporate profile of Respondent, including any experience Respondent may have with providing similar services for the same target population - Medicaid, Title XXI (state Children's Health Insurance Programs ("CHIP") or similar initiatives. This section should include a listing of previous clients for whom the Respondent has provided services similar to those being proposed under this submission.

Respondent's proposal should also include the size of the firm, the size of the firm's office that would be engaged in the performance of services under this ITN, if applicable, and the number and nature of the professional staff employed on a full-time and part-time basis.

Tab 2:

Respondent must provide documentation of the financial solvency of the organization, including audited financial statements for the organization's two (2) most recent fiscal years. If the organization's two (2) most recent fiscal years ended within 120 days prior to the proposal due date (in accordance with the ITN Calendar) and the last audited financial statement is not yet available, FHKC will consider the two (2) immediately prior fiscal years as the most recent. If audited financial statements are not routinely available, Respondent must provide other evidence of their organization's financial stability.

Tab 3:

Respondent must provide the location of the Respondent's headquarters and where the majority of staff will be located that would have primary responsibilities for the services proposed under this Contract. Respondent should indicate the percentage of services that will be delivered by staff located in Florida.

Tab 4:

Respondent's Corporate Organizational Chart with identification of key staff members who would have responsibilities if awarded this Contract. Resumes for the staff that would have primary responsibilities under this Contract should be included under this Tab.

Tab 5:

Conflict of Interest Statement and Disclosure
FHKC has a Code of Ethics which will be posted on FHKC's website with this ITN. The Respondent must review the Code of Ethics and disclose under this Tab any relationships with any members of FHKC's Board of Directors or employees. If no conflicts exist, Respondent must so affirmatively state.

Tab 6:

Affirmation attesting agreement to all terms and agreement as proposed under this ITN and proposed Contract. This attestation also must affirm that the Respondent is not de-barred or otherwise prohibited from or being eligible to receive federal or state funds.

This attestation must be signed and dated by an executive officer of the Respondent.

Tab 7:

References
Respondent must provide at least three (3) references from current or recent (within the past two (2) years) contracts of comparable population or size utilizing the form included in the Appendix to this ITN.

Tab B: Copy of Letter of Intent and Mandatory Cover Sheet

A copy of Respondent's Letter of Intent (the "LOI") must be included under Tab B.

Only those Respondents who have sent a written LOI with required Cover Sheet to the Issuing Officer by 5:00 p.m. (Eastern) on Thursday, November 10, 2011 will have their proposals considered.

The LOI should clearly identify the responding organization, a contact name and contact information including mailing address, email address, telephone number and fax number, alternate contact name and corresponding information and the counties of interest. The LOI must be signed by an executive officer of the Respondent's organization.

The required Cover Sheet is attached to this procurement document and must accompany the Letter of Intent.

The LOI is non-binding and may be withdrawn at any time by the Respondent.

Tab C: Covered Services

For each proposed service, Respondent must fully explain at a minimum the following features:

1. The organization's approach to the delivery of that service;
2. Key milestones or steps involved for timely delivery;
3. Identification of personnel that will be responsible for its success; and,
4. How the organization will ensure its timely and satisfactory delivery to FHKC.

Respondents may propose other related services not detailed above.

Tab D: Contract

If selected to provide services, a Contract will be executed between FHKC and the successful Respondent or Respondents. The proposed Contract will be posted to the Healthy Kids website after the Letter of Intent deadline.

Conflicts

Any conflicts between the proposed Contract, this ITN and the Respondent's proposal will be resolved by FHKC and included in the final Contract that is executed between the Parties.

Revisions

Revisions to FHKC's standard Contract are not generally accepted; however, the Respondent may include in its response any requested changes. Requested changes are reviewed and evaluated and points may be deducted for substantive changes. Excessive or unreasonable changes or changes that modify the program's objectives, amend substantive changes or impair FHKC's fiduciary or other contractual responsibilities may result in points being deducted or the proposal being removed from further consideration. FHKC reserves the right to reject any or all requested changes in its sole discretion.

If the Respondent anticipates requesting revisions, the specific revisions must be requested in writing in a strikethrough and underline format of the original document and submitted with the proposal.

Under this Tab, the Respondent must state explicitly its acceptance of the proposed Contract as presented. Respondents must also include a copy of their organization's letter of agreement or equivalent in the event an individual project is selected for further negotiation.

FHKC may make awards with no revisions accepted to its standard Contract.

Tab E Pricing Proposals

Respondents may submit multiple pricing proposals under this ITN. Proposals can be presented as fixed consulting fees with costs included in those fees clearly defined, deliverable based, hourly rates or project based or any combination of schedules.

However, regardless of how many combinations are presented, FHKC reserves the right to negotiate with any, all or one Respondent or Respondents for the best combination of prices and services based on the proposals as submitted without any further negotiation with the other Respondents.

FHKC may ask Respondents to restate any or all of their proposals in alternate formats after the initial submission date.

END OF MAIN PROCUREMENT DOCUMENT

APPENDIX

APPENDIX I: LETTER OF INTENT COVER SHEET

INVITATION TO NEGOTIATE

ACTUARIAL SERVICES

Organization Name:		
	Main Contact	Alternate
Names:		
Addresses:		
Phone Numbers: Office: Cell Phone\Other:		
Fax Numbers:		
E-Mails:		
Other:		

APPENDIX II: BACKGROUND INFORMATION

I. Roles of the Florida Healthy Kids Corporation

As noted in the beginning of this ITN, the Florida Healthy Kids Corporation ("FHKC") is a Florida non-profit corporation formed by the Florida Legislature in 1990 to provide health insurance coverage to school aged children. But this is only one of several roles that Healthy Kids plays today in the Florida KidCare Program.

Besides coverage for these 220,000 children as one of the three Title XXI\state Children's Health Insurance program (CHIP) components under Florida KidCare, Healthy Kids is also under contract with the state's Agency for Health Care Administration to administer Florida's CHIP. As administrator, Healthy Kids is responsible for the eligibility, enrollment, and customer service functions that are detailed more fully below.

Additionally, Healthy Kids also conducts outreach on behalf of the Florida KidCare program. While dedicated state funding for outreach has not occurred since state fiscal 2007-08 when $1 million was allocated, Healthy Kids has funded select marketing and outreach functions and activities through its corporate budget process.

II. Program Eligibility

Generally, to be eligible for the Healthy Kids program, an applicant must be uninsured at the time of application and be between the ages of 5 (five) and 19 (nineteen) years. Age eligibility is based on the child's age on the first day of the month. For example, if a child reaches the age of nineteen on the first day of the month, the coverage would cancel that month; however, if the child turns nineteen on the tenth of the month, the coverage would end on the last day of the month in which the child turned age nineteen.

Other eligibility criteria may be utilized to determine whether a child is eligible for subsidized coverage in accordance with federal and state laws and regulations. Program eligibility and premium assistance calculations are not the responsibility of the Insurer. FHKC does not identify subsidy levels of its Enrollees to Insurers.

Most families with household incomes at or below 200% of the federal poverty level ("FPL") pay a monthly premium of $15 or $20 per family per month to participate in the Program. While there is no income limit for the Healthy Kids program, a family's household size and income, or any voluntary cancellation of employer sponsored coverage for the Enrollee during the prior sixty (60) day period will determine whether subsidized coverage is available. FHKC shall make these determinations in accordance with federal and state laws and regulations.

Other factors that impact a child's ability to qualify for subsidized coverage include citizenship status and whether the child's parent is a state employee.

To be eligible for Title XXI federally subsidized coverage, a child must be a United States citizen or meet the definition of a qualified alien and a child cannot be the dependant of a state employee eligible for benefits. Enrollment of non-qualified non-citizen children was closed several years ago; however, some children were grandfathered-in and remain enrolled in the program. County funds and family contributions are used to finance this enrollment currently. Financial participation by the counties is voluntary.

New enrollees who are not eligible for subsidy are offered the opportunity to participate in the program at a non-subsidized rate.

Once a child has been determined eligible, the child is eligible for coverage for twelve (12) months, without re-determination or re-verification of eligibility. Enrollees are required to renew their coverage once every twelve (12) months based on the month of their initial enrollment in the Program or the last renewal completion date. Each Enrollee's renewal date will be provided to the Insurer in the enrollment files. Insurers are encouraged to implement their own initiatives to encourage families to complete the renewal process. All such efforts must be approved in writing by FHKC prior to implementation.

Eligibility for the program is determined by FHKC. The Insurer must accept all Enrollees deemed eligible by FHKC. The eligibility criteria for the Healthy Kids program are subject to change during the Contract term.

Additionally, eligibility for the Medicaid Program is determined by the Department of Children and Families ("DCF") and not Healthy Kids. Applicants and Enrollees eligible for the CMSN program must be both financially eligible through either Title XXI (CHIP) or Title XIX ("Medicaid") of the Social Security Act and meet clinical eligibility requirements that are established by the Florida Department of Health ("DOH"). Applicants and Enrollees, who meet the eligibility criteria described above for Medicaid or the CMSN, as determined by the responsible state agency, are not eligible for the Healthy Kids program.

Effective July 1, 2009, revisions to the Florida KidCare Act were implemented which permitted Enrollees who were both financially and clinically eligible for the CMSN program to elect to opt out of the CMSN program and enroll in the Healthy Kids program. Some Enrollees in the Healthy Kids program may meet the financial and clinical requirements for the CMSN program but have elected to enroll in the Healthy Kids program instead.

II. Enrollment

The current enrollment process is handled by FHKC and its Third Party Administrator ("TPA"). FHKC's current TPA is ACS Health Administration, Inc. ("ACS").

Families may complete a one (1) page paper Florida KidCare Application or an on-line application. Documentation of income is first attempted electronically and then if not able to be determined electronically, the family is asked to submit evidence of family income. Whether or not a child is currently insured is also part of the eligibility process; however, good cause exceptions do exist in state law.

New Enrollees are auto-assigned among the plans available in the county keeping family members together in the same plan. A copy of FHKC's policy on *Enrollee Protections Relating to Managed Care Assignments* is available on the Healthy Kids website. New Enrollees are provided a ninety (90) day free look period to change plans before a lock-in period begins. Plan changes may occur after this free look period under one of the good cause exceptions as provided in the policy.

Once approved for enrollment by FHKC, the Insurer is responsible for the distribution of member materials, including identification cards, member handbooks and provider information to Enrollees. Enrollee information is transmitted to the Insurer in the monthly eligibility files.

III. Benefits

The Healthy Kids program provides a comprehensive health services package. The minimum benefit level for this program is specified by state law, section 409.815, Florida Statutes, and cannot be modified. Comprehensive dental benefits pursuant to section 409.815(2)(q), Florida Statutes, are provided to Enrollees under separate contracts.

Insurers are required to a system for tracking each Enrollee's out-of-pocket costs so as to ensure that no Enrollee exceeds the federal cost sharing maximums. Healthy Kids makes the final determination as to whether a family has reached its maximum, and therefore, no additional co-payments can be collected from the Enrollee for the remainder of the designated year. American Indian and Alaskan Native Enrollees are also prohibited from paying any out of pocket costs towards their care.

FHKC identifies each month those Enrollees for whom no cost sharing may be collected on the monthly enrollment files. Insurers must have a mechanism for ensuring that any designed Enrollee incurs no further cost sharing for the time period designated after such notification by FHKC and that its provider network is also made aware of such policies.

IV. Delivery of Services

Insurers provide benefits through a network of designated plan providers. Provisions are made for out-of-area (including out-of-state and out-of-the-country services) emergency services and tertiary care. Providers should include pediatric specialists and facilities that specialize in pediatric services. Networks are reviewed closely to determine whether sufficient access to primary care providers and specialists is available and that access and appointment standards can be met both at Contract inception and throughout the Contract term.

It is the Insurers' responsibility to ensure an adequate service network is established and maintained that meets or exceeds contractual requirements and ensures that Enrollees' access to care is not compromised. If the Insurer does not meet the service network contractual requirements, FHKC will direct its Enrollees to seek care from any willing provider and the Insurer will be responsible for the cost of any such services that are covered under the Contract. FHKC does not contract with individual providers for services.

A. Provider Network Standards

The network must be sufficient to provide adequate appointment access and geographic distribution in accordance with contractual standards. The network must include specialists, hospitals, tertiary facilities and other providers that will adequately address the needs of a pediatric and adolescent population and support the benefit package.

The primary care network shall include only board certified pediatricians and family medicine physicians or physician extenders working under the direct supervision of a board certified practitioner. All primary care physicians must provide immunizations to Enrollees. Insurers must be able to identify and assign a medical home for each Enrollee.

B. Facility Standards

Facilities used for Enrollees shall meet applicable accreditation and licensure requirements and meet facility regulations specified by the Agency for Health Care Administration (AHCA).

C. Behavioral Health Care and Substance Abuse Providers

Insurers must have established standards of care for contracting with providers for behavioral health care and substance abuse services.

D. Geographic Access

1. Primary Care Providers

a. Medical

Geographical access to board certified family practice physicians, pediatric physicians, primary care provider experienced in child health care must be within twenty (20) minutes driving time from residence of each Enrollee to provider.

This driving time limitation may be reasonably extended in those areas where such limitation with respect to rural residence is unreasonable. In such instances, Insurer is required to provide access for urgent care through contracts with the closest available providers.

b. Dental

Geographical access to primary care dental providers experienced in child dental health are to be available within twenty (20) minutes driving time from Enrollee's residence to Provider. The driving time limitation may be reasonably extended in those areas where such limitation with respect to rural residences is unreasonable. In such instances, Insurer is required to provide access for urgent care through contracts with the closest available Providers.

2. Specialty Care Providers (Medical and Dental)

Specialty medical services, ancillary services and hospital services are to be available within sixty (60) minutes driving time from Enrollee's residence to provider. The driving time may be reasonably extended or waived in those areas where such limitation with respect to rural residences is unreasonable.

E. Appointment Standards

1. Emergency care must be provided immediately.
2. Urgently needed care shall be provided within twenty-four (24) hours of Enrollee request.
3. Routine care of Enrollees who do not require emergency or urgent care as noted above shall be provided within seven (7) calendar days of the Enrollee's request for services.

4. Routine physical examinations shall be provided within four (4) weeks of Enrollee's request.
5. Follow-Up care shall be provided as medically appropriate.
6. "Routine Dental Examinations" means the semi-annual preventive office visit including a dental cleaning and examination of an Enrollee where no specific condition has been identified.

V. Member Services

Insurers are responsible for educating Enrollees about their benefits, how to access services and the importance of preventive care. Insurer distribute new member materials, including a member handbook and identification card within five (5) business days of the receipt of an enrollment file or notice of enrollment in the case of manual additions. These member materials and member correspondence must be pre-approved in writing by FHKC prior to distribution, be available in languages other than English and must comply with federal Title XXI regulations.

FHKC also requires the Insurer to identify a medical home for each Enrollee. To accomplish the requirement, the Insurer must have a system in place to assign each Enrollee a Board Certified primary care physician to direct and manage the Enrollee's care.

Insurer's grievance process must conform to all applicable state and federal laws and regulations. Any subsequent changes to the process must be reviewed and approved by FHKC prior to implementation. Quarterly reports of grievances received from Healthy Kids' Enrollees must also be provided.

Coverage offered under this Program is considered creditable coverage for the purposes of part 7 of subtitle B of title II of ERISA, title XXVII of the Public Health Services Act and subtitle K of the Internal Revenue Code of 1986. The Insurer is responsible for issuing a certificate of creditable coverage to those eligible Enrollees.

Appendix III: Florida Healthy Kids Corporation Act

Florida Healthy Kids Corporation Act (Florida Statutes – 2010)

624.91 The Florida Healthy Kids Corporation Act.—

(1) SHORT TITLE.—This section may be cited as the "William G. 'Doc' Myers Healthy Kids Corporation Act."
(2) LEGISLATIVE INTENT.—
(a) The Legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state. Many children do not have comprehensive, affordable health care services available. It is the intent of the Legislature that the Florida Healthy Kids Corporation provide comprehensive health insurance coverage to such children. The corporation is encouraged to cooperate with any existing health service programs funded by the public or the private sector.
(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may serve other children, the Legislature intends the primary recipients of services provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds be used to continue coverage, subject to specific appropriations in the General Appropriations Act, to children not eligible for federal matching funds under Title XXI.
(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the following individuals are eligible for state-funded assistance in paying Florida Healthy Kids premiums:
(a) Residents of this state who are eligible for the Florida Kidcare program pursuant to s. 409.814.
(b) Notwithstanding s. 409.814, legal aliens who are enrolled in the Florida Healthy Kids program as of January 31, 2004, who do not qualify for Title XXI federal funds because they are not qualified aliens as defined in s. 409.811.
(4) NONENTITLEMENT.—Nothing in this section shall be construed as providing an individual with an entitlement to health care services. No cause of action shall arise against the state, the Florida Healthy Kids Corporation, or a unit of local government for failure to make health services available under this section.
(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
(a) There is created the Florida Healthy Kids Corporation, a not-for-profit corporation.
(b) The Florida Healthy Kids Corporation shall:
1. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.
2. Arrange for the collection of any voluntary contributions to provide for payment of Florida Kidcare program premiums for children who are not eligible for medical assistance under Title XIX or Title XXI of the Social Security Act.
3. Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional Florida Kidcare coverage in contributing counties under Title XXI.
4. Establish the administrative and accounting procedures for the operation of the corporation.
5. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

6. Determine eligibility for children seeking to participate in the Title XXI-funded components of the Florida Kidcare program consistent with the requirements specified in s. 409.814, as well as the non-Title-XXI-eligible children as provided in subsection (3).
7. Establish procedures under which providers of local match to, applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.
8. Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.
9. Establish enrollment criteria that include penalties or waiting periods of 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums.
10. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.
11. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.
12. Develop and implement a plan to publicize the Florida Kidcare program, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.
13. Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation.
14. In consultation with the partner agencies, provide a report on the Florida Kidcare program annually to the Governor, the Chief Financial Officer, the Commissioner of Education, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and the House of Representatives.
15. Provide information on a quarterly basis to the Legislature and the Governor which compares the costs and utilization of the full-pay enrolled population and the Title XXI-subsidized enrolled population in the Florida Kidcare program. The information, at a minimum, must include:
a. The monthly enrollment and expenditure for full-pay enrollees in the Medikids and Florida Healthy Kids programs compared to the Title XXI-subsidized enrolled population; and
b. The costs and utilization by service of the full-pay enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population.
By February 1, 2010, the Florida Healthy Kids Corporation shall provide a study to the Legislature and the Governor on premium impacts to the subsidized portion of the program from the inclusion of the full-pay program, which shall include recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.
16. Establish benefit packages that conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.821.
(c) Coverage under the corporation's program is secondary to any other available private coverage held by, or applicable to, the participant child or family member. Insurers under contract with the

corporation are the payors of last resort and must coordinate benefits with any other third-party payor that may be liable for the participant's medical care.
(d) The Florida Healthy Kids Corporation shall be a private corporation not for profit, organized pursuant to chapter 617, and shall have all powers necessary to carry out the purposes of this act, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this act.
(6) BOARD OF DIRECTORS.—
(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors chaired by the Chief Financial Officer or her or his designee, and composed of 11 other members selected for 3-year terms of office as follows:
1. The Secretary of Health Care Administration, or his or her designee.
2. One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education.
3. One member appointed by the Chief Financial Officer from among three members nominated by the Florida Pediatric Society.
4. One member, appointed by the Governor, who represents the Children's Medical Services Program.
5. One member appointed by the Chief Financial Officer from among three members nominated by the Florida Hospital Association.
6. One member, appointed by the Governor, who is an expert on child health policy.
7. One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Academy of Family Physicians.
8. One member, appointed by the Governor, who represents the state Medicaid program.
9. One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Association of Counties.
10. The State Health Officer or her or his designee.
[1]11. The Secretary of Children and Family Services, or his or her designee.
(b) A member of the board of directors may be removed by the official who appointed that member. The board shall appoint an executive director, who is responsible for other staff authorized by the board.
(c) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061.
(d) There shall be no liability on the part of, and no cause of action shall arise against, any member of the board of directors, or its employees or agents, for any action they take in the performance of their powers and duties under this act.
(7) LICENSING NOT REQUIRED; FISCAL OPERATION.—
(a) The corporation shall not be deemed an insurer. The officers, directors, and employees of the corporation shall not be deemed to be agents of an insurer. Neither the corporation nor any officer, director, or employee of the corporation is subject to the licensing requirements of the insurance code or the rules of the Department of Financial Services. However, any marketing representative utilized and compensated by the corporation must be appointed as a representative of the insurers or health services providers with which the corporation contracts.
(b) The board has complete fiscal control over the corporation and is responsible for all corporate operations.
(c) The Department of Financial Services shall supervise any liquidation or dissolution of the corporation and shall have, with respect to such liquidation or dissolution, all power granted to it pursuant to the insurance code.

History.—s. 1, ch. 90-199; s. 1, ch. 91-188; s. 30, ch. 91-201; s. 5, ch. 91-429; s. 7, ch. 93-78; s. 21, ch. 93-129; s. 1, ch. 96-337; s. 368, ch. 96-406; s. 28, ch. 96-418; s. 9, ch. 96-420; s. 1722, ch. 97-102; s. 8, ch. 97-153; s. 54, ch. 98-288; s. 5, ch. 99-357; s. 20, ch. 2001-377; s. 32, ch. 2002-400; s. 14, ch. 2002-404; s. 21, ch. 2003-405; s. 6, ch.

2004-1; s. 20, ch. 2004-270; s. 84, ch. 2006-1; s. 18, ch. 2006-2; s. 23, ch. 2006-28; s. 7, ch. 2008-32; s. 3, ch. 2008-146; s. 1, ch. 2009-41; s. 13, ch. 2009-113; s. 119, ch. 2010-5.

[1]Note.—As created by s. 13, ch. 2009-113. For a description of multiple acts in the same session affecting a statutory provision, see preface to the Florida Statutes, "Statutory Construction." Subparagraph 11. was also created by s. 1, ch. 2009-41, and that version reads:

11. One member, appointed by the Governor, from among three members nominated by the Florida Dental Association.

Appendix IV: Florida KidCare Act

409.810 Short title.—
Sections 409.810-409.821 may be cited as the "Florida Kidcare Act."
History.—ss. 32, 57, ch. 98-288; s. 22, ch. 2003-405; s. 1, ch. 2009-113.

409.811 Definitions relating to Florida Kidcare Act.—
As used in ss. 409.810-409.821, the term:
(1) "Actuarially equivalent" means that:
(a) The aggregate value of the benefits included in health benefits coverage is equal to the value of the benefits in the benchmark benefit plan; and
(b) The benefits included in health benefits coverage are substantially similar to the benefits included in the benchmark benefit plan, except that preventive health services must be the same as in the benchmark benefit plan.
(2) "Agency" means the Agency for Health Care Administration.
(3) "Applicant" means a parent or guardian of a child or a child whose disability of nonage has been removed under chapter 743, who applies for determination of eligibility for health benefits coverage under ss. 409.810-409.821.
(4) "Benchmark benefit plan" means the form and level of health benefits coverage established in s. 409.815.
(5) "Child" means any person under 19 years of age.
(6) "Child with special health care needs" means a child whose serious or chronic physical or developmental condition requires extensive preventive and maintenance care beyond that required by typically healthy children. Health care utilization by such a child exceeds the statistically expected usage of the normal child adjusted for chronological age, and such a child often needs complex care requiring multiple providers, rehabilitation services, and specialized equipment in a number of different settings.
(7) "Children's Medical Services Network" or "network" means a statewide managed care service system as defined in s. 391.021(1).
(8) "Community rate" means a method used to develop premiums for a health insurance plan that spreads financial risk across a large population and allows adjustments only for age, gender, family composition, and geographic area.
(9) "Department" means the Department of Health.
(10) "Enrollee" means a child who has been determined eligible for and is receiving coverage under ss. 409.810-409.821.
(11) "Family" means the group or the individuals whose income is considered in determining eligibility for the Florida Kidcare program. The family includes a child with a parent or caretaker relative who resides in the same house or living unit or, in the case of a child whose disability of nonage has been removed under chapter 743, the child. The family may also include other individuals whose income and resources are considered in whole or in part in determining eligibility of the child.
(12) "Family income" means cash received at periodic intervals from any source, such as wages, benefits, contributions, or rental property. Income also may include any money that would have been counted as income under the Aid to Families with Dependent Children (AFDC) state plan in effect prior to August 22, 1996.
(13) "Florida Kidcare program," "Kidcare program," or "program" means the health benefits program administered through ss. 409.810-409.821.
(14) "Guarantee issue" means that health benefits coverage must be offered to an individual regardless of the individual's health status, preexisting condition, or claims history.
(15) "Health benefits coverage" means protection that provides payment of benefits for covered health care services or that otherwise provides, either directly or through arrangements with other

persons, covered health care services on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(16) "Health insurance plan" means health benefits coverage under the following:

(a) A health plan offered by any certified health maintenance organization or authorized health insurer, except a plan that is limited to the following: a limited benefit, specified disease, or specified accident; hospital indemnity; accident only; limited benefit convalescent care; Medicare supplement; credit disability; dental; vision; long-term care; disability income; coverage issued as a supplement to another health plan; workers' compensation liability or other insurance; or motor vehicle medical payment only; or

(b) An employee welfare benefit plan that includes health benefits established under the Employee Retirement Income Security Act of 1974, as amended.

(17) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and ss. 409.901-409.920, as administered in this state by the agency.

(18) "Medically necessary" means the use of any medical treatment, service, equipment, or supply necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity and which is:

(a) Consistent with the symptom, diagnosis, and treatment of the enrollee's condition;

(b) Provided in accordance with generally accepted standards of medical practice;

(c) Not primarily intended for the convenience of the enrollee, the enrollee's family, or the health care provider;

(d) The most appropriate level of supply or service for the diagnosis and treatment of the enrollee's condition; and

(e) Approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the enrollee's condition.

(19) "Medikids" means a component of the Florida Kidcare program of medical assistance authorized by Title XXI of the Social Security Act, and regulations thereunder, and s. 409.8132, as administered in the state by the agency.

(20) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(21) "Premium" means the entire cost of a health insurance plan, including the administration fee or the risk assumption charge.

(22) "Premium assistance payment" means the monthly consideration paid by the agency per enrollee in the Florida Kidcare program towards health insurance premiums.

(23) "Qualified alien" means an alien as defined in s. 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.

(24) "Resident" means a United States citizen, or qualified alien, who is domiciled in this state.

(25) "Rural county" means a county having a population density of less than 100 persons per square mile, or a county defined by the most recent United States Census as rural, in which there is no prepaid health plan participating in the Medicaid program as of July 1, 1998.

(26) "Substantially similar" means that, with respect to additional services as defined in s. 2103(c)(2) of Title XXI of the Social Security Act, these services must have an actuarial value equal to at least 75 percent of the actuarial value of the coverage for that service in the benchmark benefit plan and, with respect to the basic services as defined in s. 2103(c)(1) of Title XXI of the Social Security Act, these services must be the same as the services in the benchmark benefit plan.

History.—ss. 33, 57, ch. 98-288; s. 22, ch. 2003-405; s. 1, ch. 2004-1; s. 5, ch. 2006-28; s. 27, ch. 2008-61; s. 2, ch. 2009-113.

409.812 Program created; purpose.—

The Florida Kidcare program is created to provide a defined set of health benefits to uninsured, low-income children through the establishment of a variety of affordable health benefits coverage options from which families may select coverage and through which families may contribute financially to the health care of their children.
History.—ss. 34, 57, ch. 98-288; s. 22, ch. 2003-405; s. 3, ch. 2009-113.

409.813 Health benefits coverage; program components; entitlement and nonentitlement.—

(1) The Florida Kidcare program includes health benefits coverage provided to children through the following program components, which shall be marketed as the Florida Kidcare program:
(a) Medicaid;
(b) Medikids as created in s. 409.8132;
(c) The Florida Healthy Kids Corporation as created in s. 624.91;
(d) Employer-sponsored group health insurance plans approved under ss. 409.810-409.821; and
(e) The Children's Medical Services network established in chapter 391.
(2) Except for Title XIX-funded Florida Kidcare program coverage under the Medicaid program, coverage under the Florida Kidcare program is not an entitlement. No cause of action shall arise against the state, the department, the Department of Children and Family Services, or the agency for failure to make health services available to any person under ss. 409.810-409.821.
History.—ss. 35, 57, ch. 98-288; s. 22, ch. 2003-405; s. 4, ch. 2009-113.

409.8132 Medikids program component.—

(1) PROGRAM COMPONENT CREATED; PURPOSE.—The Medikids program component is created in the Agency for Health Care Administration to provide health care services under the Florida Kidcare program to eligible children using the administrative structure and provider network of the Medicaid program.
(2) ADMINISTRATION.—The secretary of the agency shall appoint an administrator of the Medikids program component. The Agency for Health Care Administration is designated as the state agency authorized to make payments for medical assistance and related services for the Medikids program component of the Florida Kidcare program. Payments shall be made, subject to any limitations or directions in the General Appropriations Act, only for covered services provided to eligible children by qualified health care providers under the Florida Kidcare program.
(3) INSURANCE LICENSURE NOT REQUIRED.—The Medikids program component shall not be subject to the licensing requirements of the Florida Insurance Code or rules adopted thereunder.
(4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, 409.9121, 409.9122, 409.9123, 409.9124, 409.9127, 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply to the administration of the Medikids program component of the Florida Kidcare program, except that s. 409.9122 applies to Medikids as modified by the provisions of subsection (7).
(5) BENEFITS.—Benefits provided under the Medikids program component shall be the same benefits provided to children as specified in ss. 409.905 and 409.906.
(6) ELIGIBILITY.—
(a) A child who has attained the age of 1 year but who is under the age of 5 years is eligible to enroll in the Medikids program component of the Florida Kidcare program, if the child is a member of a family that has a family income which exceeds the Medicaid applicable income level as specified in s. 409.903, but which is equal to or below 200 percent of the current federal poverty level. In determining the eligibility of such a child, an assets test is not required. A child who is eligible for Medikids may elect to enroll in Florida Healthy Kids coverage or employer-sponsored group coverage. However, a child who is eligible for Medikids may participate in the Florida Healthy Kids program only if the child has a sibling participating in the Florida Healthy Kids program and the child's county of residence permits such enrollment.

(b) The provisions of s. 409.814(3), (4), (5), and (6) shall be applicable to the Medikids program.
(7) ENROLLMENT.—Enrollment in the Medikids program component may occur at any time throughout the year. A child may not receive services under the Medikids program until the child is enrolled in a managed care plan or MediPass. Once determined eligible, an applicant may receive choice counseling and select a managed care plan or MediPass. The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's voluntary choice period ends. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients and only if the federal Health Care Financing Administration determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act.
(8) PENALTIES FOR VOLUNTARY CANCELLATION.—The agency shall establish enrollment criteria that include penalties or waiting periods of 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of premiums.
History.—ss. 36, 57, ch. 98-288; s. 2, ch. 2000-253; s. 18, ch. 2000-305; s. 13, ch. 2002-400; s. 446, ch. 2003-261; s. 22, ch. 2003-405; s. 2, ch. 2004-1; s. 1, ch. 2005-123; s. 5, ch. 2009-113.

409.8134 Program expenditure ceiling; enrollment.—

(1) Except for the Medicaid program, a ceiling shall be placed on annual federal and state expenditures for the Florida Kidcare program as provided each year in the General Appropriations Act.
(2) The Florida Kidcare program may conduct enrollment continuously throughout the year. Children eligible for coverage under the Title XXI-funded Florida Kidcare program shall be enrolled on a first-come, first-served basis using the date the enrollment application is received. Enrollment shall immediately cease when the expenditure ceiling is reached. Year-round enrollment shall only be held if the Social Services Estimating Conference determines that sufficient federal and state funds will be available to finance the increased enrollment. The application for the Florida Kidcare program is 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 is invalid and the applicant shall be notified of the action. The applicant may reactivate the application after notification of the action taken by the program. Except for the Medicaid program, whenever the Social Services Estimating Conference determines that there are presently, or will be by the end of the current fiscal year, insufficient funds to finance the current or projected enrollment in the Florida Kidcare program, all additional enrollment must cease and additional enrollment may not resume until sufficient funds are available to finance such enrollment.
(3) Upon determination by the Social Services Estimating Conference that there are insufficient funds to finance the current enrollment in the Florida Kidcare program within current appropriations, the program shall initiate disenrollment procedures to remove enrollees, except those children enrolled in the Children's Medical Services Network, on a last-in, first-out basis until the expenditure and appropriation levels are balanced.
(4) The agencies that administer the Florida Kidcare program components shall collect and analyze the data needed to project program enrollment costs, including price level adjustments, participation and attrition rates, current and projected caseloads, utilization, and current and projected expenditures for the next 3 years. The agencies shall report caseload and expenditure trends to the Social Services Estimating Conference in accordance with chapter 216.
History.—ss. 37, 57, ch. 98-288; s. 3, ch. 2000-253; s. 22, ch. 2003-405; s. 3, ch. 2004-1; s. 3, ch. 2004-270; s. 2, ch. 2005-123; s. 6, ch. 2006-28; s. 6, ch. 2009-113.

409.8135 Behavioral health services.—
In order to ensure a high level of integration of physical and behavioral health care and to meet the more intensive treatment needs of enrollees with the most serious emotional disturbances or substance abuse problems, the Department of Health shall contract with the Department of Children

and Family Services to provide behavioral health services to non-Medicaid-eligible children with special health care needs. The Department of Children and Family Services, in consultation with the Department of Health and the agency, is authorized to establish the following:
(1) The scope of behavioral health services, including duration and frequency.
(2) Clinical guidelines for referral to behavioral health services.
(3) Behavioral health services standards.
(4) Performance-based measures and outcomes for behavioral health services.
(5) Practice guidelines for behavioral health services to ensure cost-effective treatment and to prevent unnecessary expenditures.
(6) Rules to implement this section.
History.—ss. 38, 57, ch. 98-288; s. 22, ch. 2003-405.

409.814 Eligibility.—

A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. For enrollment in the Children's Medical Services Network, a complete application includes the medical or behavioral health screening. If, subsequently, an individual is determined to be ineligible for coverage, he or she must immediately be disenrolled from the respective Florida Kidcare program component.
(1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be enrolled in Medicaid and is not eligible to receive health benefits under any other health benefits coverage authorized under the Florida Kidcare program.
(2) A child who is not eligible for Medicaid, but who is eligible for the Florida Kidcare program, may obtain health benefits coverage under any of the other components listed in s. 409.813 if such coverage is approved and available in the county in which the child resides.
(3) A Title XXI-funded child who is eligible for the Florida Kidcare program who is a child with special health care needs, as determined through a medical or behavioral screening instrument, is eligible for health benefits coverage from and shall be assigned to and may opt out of the Children's Medical Services Network.
(4) The following children are not eligible to receive Title XXI-funded premium assistance for health benefits coverage under the Florida Kidcare program, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:
(a) A child who is eligible for coverage under a state health benefit plan on the basis of a family member's employment with a public agency in the state.
(b) A child who is covered under a family member's group health benefit plan or under other private or employer health insurance coverage, if the cost of the child's participation is not greater than 5 percent of the family's income. If a child is otherwise eligible for a subsidy under the Florida Kidcare program and the cost of the child's participation in the family member's health insurance benefit plan is greater than 5 percent of the family's income, the child may enroll in the appropriate subsidized Kidcare program.
(c) A child who is seeking premium assistance for the Florida Kidcare program through employer-sponsored group coverage, if the child has been covered by the same employer's group coverage during the 60 days prior to the family's submitting an application for determination of eligibility under the program.
(d) A child who is an alien, but who does not meet the definition of qualified alien, in the United States.
(e) A child who is an inmate of a public institution or a patient in an institution for mental diseases.
(f) A child who is otherwise eligible for premium assistance for the Florida Kidcare program and has had his or her coverage in an employer-sponsored or private health benefit plan voluntarily canceled in the last 60 days, except those children whose coverage was voluntarily canceled for good cause, including, but not limited to, the following circumstances:

1. The cost of participation in an employer-sponsored health benefit plan is greater than 5 percent of the family's 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.

(5) A child who is otherwise eligible for the Florida Kidcare program and who has a preexisting condition that prevents coverage under another insurance plan as described in paragraph (4)(b) which would have disqualified the child for the Florida Kidcare program if the child were able to enroll in the plan shall be eligible for Florida Kidcare coverage when enrollment is possible.

(6) A child whose family income is above 200 percent of the federal poverty level or a child who is excluded under the provisions of subsection (4) may participate in the Florida Kidcare program as provided in s. 409.8132 or, if the child is ineligible for Medikids by reason of age, in the Florida Healthy Kids program, subject to the following provisions:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the premium, including any administrative costs.

(b) The board of directors of the Florida Healthy Kids Corporation may offer a reduced benefit package to these children in order to limit program costs for such families.

(7) Once a child is enrolled in the Florida Kidcare program, the child is eligible for coverage under the program for 12 months without a redetermination or reverification of eligibility, if the family continues to pay the applicable premium. Eligibility for program components funded through Title XXI of the Social Security Act shall terminate when a child attains the age of 19. A child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility.

(8) When determining or reviewing a child's eligibility under the Florida Kidcare program, the applicant shall be provided with reasonable notice of changes in eligibility which may affect enrollment in one or more of the program components. When a transition from one program component to another is authorized, there shall be cooperation between the program components and the affected family which promotes continuity of health care coverage. Any authorized transfers must be managed within the program's overall appropriated or authorized levels of funding. Each component of the program shall establish a reserve to ensure that transfers between components will be accomplished within current year appropriations. These reserves shall be reviewed by each convening of the Social Services Estimating Conference to determine the adequacy of such reserves to meet actual experience.

(9) In determining the eligibility of a child, an assets test is not required. Each applicant shall provide documentation during the application process and the redetermination process, including, but not limited to, the following:

(a) Each applicant's proof of family income shall be verified electronically to determine financial eligibility for the Florida Kidcare program. Written documentation, which may include wages and earnings statements or pay stubs, W-2 forms, or a copy of the applicant's most recent federal income tax return, shall be required only if the electronic verification is not available or does not substantiate the applicant's income.

(b) Each applicant shall provide a statement from all applicable, employed family members that:
1. Their employers do not sponsor health benefit plans for employees;
2. The potential enrollee is not covered by an employer-sponsored health benefit plan; or
3. The potential enrollee is covered by an employer-sponsored health benefit plan and the cost of the employer-sponsored health benefit plan is more than 5 percent of the family's income.

(10) Subject to paragraph (4)(b), the Florida Kidcare program shall withhold benefits from an enrollee if the program obtains evidence that the enrollee is no longer eligible, submitted incorrect or fraudulent information in order to establish eligibility, or failed to provide verification of eligibility. The applicant or enrollee shall be notified that because of such evidence program benefits will be withheld unless the applicant or enrollee contacts a designated representative of the program by a specified date, which must be within 10 working days after the date of notice, to discuss and resolve the matter. The program shall make every effort to resolve the matter within a timeframe that will not cause benefits to be withheld from an eligible enrollee.
(11) The following individuals may be subject to prosecution in accordance with s. 414.39:
(a) An applicant obtaining or attempting to obtain benefits for a potential enrollee under the Florida Kidcare program when the applicant knows or should have known the potential enrollee does not qualify for the Florida Kidcare program.
(b) An individual who assists an applicant in obtaining or attempting to obtain benefits for a potential enrollee under the Florida Kidcare program when the individual knows or should have known the potential enrollee does not qualify for the Florida Kidcare program.
History.—ss. 39, 57, ch. 98-288; s. 4, ch. 2000-253; s. 22, ch. 2003-405; s. 4, ch. 2004-1; ss. 4, 5, ch. 2004-270; s. 1, ch. 2004-478; s. 50, ch. 2006-1; s. 7, ch. 2006-28; s. 1, ch. 2006-248; s. 5, ch. 2008-32; s. 7, ch. 2009-113.

409.815 Health benefits coverage; limitations.—

(1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare program, benefits available under Medicaid and Medikids include those goods and services provided under the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, as administered in this state by the agency. This includes those mandatory Medicaid services authorized under s. 409.905 and optional Medicaid services authorized under s. 409.906, rendered on behalf of eligible individuals by qualified providers, in accordance with federal requirements for Title XIX, subject to any limitations or directions provided for in the General Appropriations Act or chapter 216, and according to methodologies and limitations set forth in agency rules and policy manuals and handbooks incorporated by reference thereto.
(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.
(a) Preventive health services.—Covered services include:
1. Well-child care, including services recommended in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics;
2. Immunizations and injections;
3. Health education counseling and clinical services;
4. Vision screening; and
5. Hearing screening.
(b) Inpatient hospital services.—All covered services provided for the medical care and treatment of an enrollee who is admitted as an inpatient to a hospital licensed under part I of chapter 395, with the following exceptions:
1. All admissions must be authorized by the enrollee's health benefits coverage provider.
2. The length of the patient stay shall be determined based on the medical condition of the enrollee in relation to the necessary and appropriate level of care.
3. Room and board may be limited to semiprivate accommodations, unless a private room is considered medically necessary or semiprivate accommodations are not available.
4. Admissions for rehabilitation and physical therapy are limited to 15 days per contract year.
(c) Emergency services.—Covered services include visits to an emergency room or other licensed facility if needed immediately due to an injury or illness and delay means risk of permanent damage

to the enrollee's health. Health maintenance organizations shall comply with the provisions of s. 641.513.

(d) Maternity services.—Covered services include maternity and newborn care, including prenatal and postnatal care, with the following limitations:

1. Coverage may be limited to the fee for vaginal deliveries; and

2. Initial inpatient care for newborn infants of enrolled adolescents shall be covered, including normal newborn care, nursery charges, and the initial pediatric or neonatal examination, and the infant may be covered for up to 3 days following birth.

(e) Organ transplantation services.—Covered services include pretransplant, transplant, and postdischarge services and treatment of complications after transplantation for transplants deemed necessary and appropriate within the guidelines set by the Organ Transplant Advisory Council under s. 765.53 or the Bone Marrow Transplant Advisory Panel under s. 627.4236.

(f) Outpatient services.—Covered services include preventive, diagnostic, therapeutic, palliative care, and other services provided to an enrollee in the outpatient portion of a health facility licensed under chapter 395, except for the following limitations:

1. Services must be authorized by the enrollee's health benefits coverage provider; and

2. Treatment for temporomandibular joint disease (TMJ) is specifically excluded.

(g) Behavioral health services.—

1. Mental health benefits include:

a. Inpatient services, limited to 30 inpatient days per contract year for psychiatric admissions, or residential services in facilities licensed under s. 394.875(6) or s. 395.003 in lieu of inpatient psychiatric admissions; however, a minimum of 10 of the 30 days shall be available only for inpatient psychiatric services if authorized by a physician; and

b. Outpatient services, including outpatient visits for psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional, limited to 40 outpatient visits each contract year.

2. Substance abuse services include:

a. Inpatient services, limited to 7 inpatient days per contract year for medical detoxification only and 30 days of residential services; and

b. Outpatient services, including evaluation, diagnosis, and treatment by a licensed practitioner, limited to 40 outpatient visits per contract year.

Effective October 1, 2009, covered services include inpatient and outpatient services for mental and nervous disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Such benefits include psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional and inpatient, outpatient, and residential treatment of substance abuse disorders. Any benefit limitations, including duration of services, number of visits, or number of days for hospitalization or residential services, shall not be any less favorable than those for physical illnesses generally. The program may also implement appropriate financial incentives, peer review, utilization requirements, and other methods used for the management of benefits provided for other medical conditions in order to reduce service costs and utilization without compromising quality of care.

(h) Durable medical equipment.—Covered services include equipment and devices that are medically indicated to assist in the treatment of a medical condition and specifically prescribed as medically necessary, with the following limitations:

1. Low-vision and telescopic aides are not included.

2. Corrective lenses and frames may be limited to one pair every 2 years, unless the prescription or head size of the enrollee changes.

3. Hearing aids shall be covered only when medically indicated to assist in the treatment of a medical condition.

4. Covered prosthetic devices include artificial eyes and limbs, braces, and other artificial aids.

(i) Health practitioner services.—Covered services include services and procedures rendered to an enrollee when performed to diagnose and treat diseases, injuries, or other conditions, including care rendered by health practitioners acting within the scope of their practice, with the following exceptions:

1. Chiropractic services shall be provided in the same manner as in the Florida Medicaid program.
2. Podiatric services may be limited to one visit per day totaling two visits per month for specific foot disorders.

(j) Home health services.—Covered services include prescribed home visits by both registered and licensed practical nurses to provide skilled nursing services on a part-time intermittent basis, subject to the following limitations:

1. Coverage may be limited to include skilled nursing services only;
2. Meals, housekeeping, and personal comfort items may be excluded; and
3. Private duty nursing is limited to circumstances where such care is medically necessary.

(k) Hospice services.—Covered services include reasonable and necessary services for palliation or management of an enrollee's terminal illness, with the following exceptions:

1. Once a family elects to receive hospice care for an enrollee, other services that treat the terminal condition will not be covered; and
2. Services required for conditions totally unrelated to the terminal condition are covered to the extent that the services are included in this section.

(l) Laboratory and X-ray services.—Covered services include diagnostic testing, including clinical radiologic, laboratory, and other diagnostic tests.

(m) Nursing facility services.—Covered services include regular nursing services, rehabilitation services, drugs and biologicals, medical supplies, and the use of appliances and equipment furnished by the facility, with the following limitations:

1. All admissions must be authorized by the health benefits coverage provider.
2. The length of the patient stay shall be determined based on the medical condition of the enrollee in relation to the necessary and appropriate level of care, but is limited to not more than 100 days per contract year.
3. Room and board may be limited to semiprivate accommodations, unless a private room is considered medically necessary or semiprivate accommodations are not available.
4. Specialized treatment centers and independent kidney disease treatment centers are excluded.
5. Private duty nurses, television, and custodial care are excluded.
6. Admissions for rehabilitation and physical therapy are limited to 15 days per contract year.

(n) Prescribed drugs.—

1. Coverage shall include drugs prescribed for the treatment of illness or injury when prescribed by a licensed health practitioner acting within the scope of his or her practice.
2. Prescribed drugs may be limited to generics if available and brand name products if a generic substitution is not available, unless the prescribing licensed health practitioner indicates that a brand name is medically necessary.
3. Prescribed drugs covered under this section shall include all prescribed drugs covered under the Florida Medicaid program.

(o) Therapy services.—Covered services include rehabilitative services, including occupational, physical, respiratory, and speech therapies, with the following limitations:

1. Services must be for short-term rehabilitation where significant improvement in the enrollee's condition will result; and
2. Services shall be limited to not more than 24 treatment sessions within a 60-day period per episode or injury, with the 60-day period beginning with the first treatment.

(p) Transportation services.—Covered services include emergency transportation required in response to an emergency situation.

(q) Dental services.—Effective October 1, 2009, dental services shall be covered as required under federal law and may also include those dental benefits provided to children by the Florida Medicaid program under s. 409.906(6).

(r) Lifetime maximum.—Health benefits coverage obtained under ss. 409.810-409.820 shall pay an enrollee's covered expenses at a lifetime maximum of $1 million per covered child.
(s) Cost-sharing.—Cost-sharing provisions must comply with s. 409.816.
(t) Exclusions.—
1. Experimental or investigational procedures that have not been clinically proven by reliable evidence are excluded;
2. Services performed for cosmetic purposes only or for the convenience of the enrollee are excluded; and
3. Abortion may be covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
(u) Enhancements to minimum requirements.—
1. This section sets the minimum benefits that must be included in any health benefits coverage, other than Medicaid or Medikids coverage, offered under ss. 409.810-409.821. Health benefits coverage may include additional benefits not included under this subsection, but may not include benefits excluded under paragraph (s).
2. Health benefits coverage may extend any limitations beyond the minimum benefits described in this section.

Except for the Children's Medical Services Network, the agency may not increase the premium assistance payment for either additional benefits provided beyond the minimum benefits described in this section or the imposition of less restrictive service limitations.

(v) Applicability of other state laws.—Health insurers, health maintenance organizations, and their agents are subject to the provisions of the Florida Insurance Code, except for any such provisions waived in this section.
1. Except as expressly provided in this section, a law requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to a health insurance plan policy or contract offered or delivered under ss. 409.810-409.821 unless that law is made expressly applicable to such policies or contracts.
2. Notwithstanding chapter 641, a health maintenance organization may issue contracts providing benefits equal to, exceeding, or actuarially equivalent to the benchmark benefit plan authorized by this section and may pay providers located in a rural county negotiated fees or Medicaid reimbursement rates for services provided to enrollees who are residents of the rural county.
(w) Reimbursement of federally qualified health centers and rural health clinics.—Effective October 1, 2009, payments for services provided to enrollees by federally qualified health centers and rural health clinics under this section shall be reimbursed using the Medicaid Prospective Payment System as provided for under s. 2107(e)(1)(D) of the Social Security Act. If such services are paid for by health insurers or health care providers under contract with the Florida Healthy Kids Corporation, such entities are responsible for this payment. The agency may seek any available federal grants to assist with this transition.
History.—ss. 40, 57, ch. 98-288; s. 5, ch. 2000-253; s. 19, ch. 2001-377; s. 45, ch. 2003-1; ss. 6, 22, ch. 2003-405; s. 5, ch. 2004-1; s. 135, ch. 2007-230; s. 2, ch. 2009-55; s. 8, ch. 2009-113.

409.816 Limitations on premiums and cost-sharing.—The following limitations on premiums and cost-sharing are established for the program.
(1) Enrollees who receive coverage under the Medicaid program may not be required to pay:
(a) Enrollment fees, premiums, or similar charges; or
(b) Copayments, deductibles, coinsurance, or similar charges.
(2) Enrollees in families with a family income equal to or below 150 percent of the federal poverty level, who are not receiving coverage under the Medicaid program, may not be required to pay:

(a) Enrollment fees, premiums, or similar charges that exceed the maximum monthly charge permitted under s. 1916(b)(1) of the Social Security Act; or
(b) Copayments, deductibles, coinsurance, or similar charges that exceed a nominal amount, as determined consistent with regulations referred to in s. 1916(a)(3) of the Social Security Act. However, such charges may not be imposed for preventive services, including well-baby and well-child care, age-appropriate immunizations, and routine hearing and vision screenings.
(3) Enrollees in families with a family income above 150 percent of the federal poverty level who are not receiving coverage under the Medicaid program or who are not eligible under s. 409.814(6) may be required to pay enrollment fees, premiums, copayments, deductibles, coinsurance, or similar charges on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all children in a family may not exceed 5 percent of the family's income. However, copayments, deductibles, coinsurance, or similar charges may not be imposed for preventive services, including well-baby and well-child care, age-appropriate immunizations, and routine hearing and vision screenings.
History.—ss. 41, 57, ch. 98-288; s. 22, ch. 2003-405; s. 9, ch. 2009-113; s. 91, ch. 2010-5.

409.817 Approval of health benefits coverage; financial assistance.—
In order for health insurance coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage must:
(1) Be certified by the Office of Insurance Regulation of the Financial Services Commission under s. 409.818 as meeting, exceeding, or being actuarially equivalent to the benchmark benefit plan;
(2) Be guarantee issued;
(3) Be community rated;
(4) Not impose any preexisting condition exclusion for covered benefits; however, group health insurance plans may permit the imposition of a preexisting condition exclusion, but only insofar as it is permitted under s. 627.6561;
(5) Comply with the applicable limitations on premiums and cost-sharing in s. 409.816;
(6) Comply with the quality assurance and access standards developed under s. 409.820; and
(7) Establish periodic open enrollment periods, which may not occur more frequently than quarterly.
History.—ss. 42, 57, ch. 98-288; s. 447, ch. 2003-261; s. 22, ch. 2003-405; s. 10, ch. 2009-113.

409.8175 Delivery of services in rural counties.—
A health maintenance organization or a health insurer may reimburse providers located in a rural county according to the Medicaid fee schedule for services provided to enrollees in rural counties if the provider agrees to accept such fee schedule.
History.—ss. 43, 57, ch. 98-288; s. 22, ch. 2003-405.

409.8177 Program evaluation.—
(1) The agency, in consultation with the Department of Health, the Department of Children and Family Services, and the Florida Healthy Kids Corporation, shall contract for an evaluation of the Florida Kidcare program and shall by January 1 of each year submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of the program. In addition to the items specified under s. 2108 of Title XXI of the Social Security Act, the report shall include an assessment of crowd-out and access to health care, as well as the following:
(a) An assessment of the operation of the program, including the progress made in reducing the number of uncovered low-income children.
(b) An assessment of the effectiveness in increasing the number of children with creditable health coverage, including an assessment of the impact of outreach.
(c) The characteristics of the children and families assisted under the program, including ages of the children, family income, and access to or coverage by other health insurance prior to the program and after disenrollment from the program.
(d) The quality of health coverage provided, including the types of benefits provided.

(e) The amount and level, including payment of part or all of any premium, of assistance provided.
(f) The average length of coverage of a child under the program.
(g) The program's choice of health benefits coverage and other methods used for providing child health assistance.
(h) The sources of nonfederal funding used in the program.
(i) An assessment of the effectiveness of the Florida Kidcare program, including Medicaid, the Florida Healthy Kids program, Medikids, and the Children's Medical Services network, and other public and private programs in the state in increasing the availability of affordable quality health insurance and health care for children.
(j) A review and assessment of state activities to coordinate the program with other public and private programs.
(k) An analysis of changes and trends in the state that affect the provision of health insurance and health care to children.
(l) A description of any plans the state has for improving the availability of health insurance and health care for children.
(m) Recommendations for improving the program.
(n) Other studies as necessary.
(2) The agency shall submit each month to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of enrollment for each program component of the Florida Kidcare program.
History.—ss. 44, 57, ch. 98-288; s. 6, ch. 2000-253; s. 14, ch. 2002-400; s. 22, ch. 2003-405; s. 11, ch. 2009-113.

409.818 Administration.—
In order to implement ss. 409.810-409.821, the following agencies shall have the following duties:
(1) The Department of Children and Family Services shall:
(a) Develop a simplified eligibility application mail-in form to be used for determining the eligibility of children for coverage under the Florida Kidcare program, in consultation with the agency, the Department of Health, and the Florida Healthy Kids Corporation. The simplified eligibility application form must include an item that provides an opportunity for the applicant to indicate whether coverage is being sought for a child with special health care needs. Families applying for children's Medicaid coverage must also be able to use the simplified application form without having to pay a premium.
(b) Establish and maintain the eligibility determination process under the program except as specified in subsection (5). The department shall directly, or through the services of a contracted third-party administrator, establish and maintain a process for determining eligibility of children for coverage under the program. The eligibility determination process must be used solely for determining eligibility of applicants for health benefits coverage under the program. The eligibility determination process must include an initial determination of eligibility for any coverage offered under the program, as well as a redetermination or reverification of eligibility each subsequent 6 months. Effective January 1, 1999, a child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility. In conducting an eligibility determination, the department shall determine if the child has special health care needs. The department, in consultation with the Agency for Health Care Administration and the Florida Healthy Kids Corporation, shall develop procedures for redetermining eligibility which enable a family to easily update any change in circumstances which could affect eligibility. The department may accept changes in a family's status as reported to the department by the Florida Healthy Kids Corporation without requiring a new application from the family. Redetermination of a child's eligibility for Medicaid may not be linked to a child's eligibility determination for other programs.
(c) Inform program applicants about eligibility determinations and provide information about eligibility of applicants to the Florida Kidcare program and to insurers and their agents, through a centralized coordinating office.

(d) Adopt rules necessary for conducting program eligibility functions.
(2) The Department of Health shall:
(a) Design an eligibility intake process for the program, in coordination with the Department of Children and Family Services, the agency, and the Florida Healthy Kids Corporation. The eligibility intake process may include local intake points that are determined by the Department of Health in coordination with the Department of Children and Family Services.
(b) Chair a state-level Florida Kidcare coordinating council to review and make recommendations concerning the implementation and operation of the program. The coordinating council shall include representatives from the department, the Department of Children and Family Services, the agency, the Florida Healthy Kids Corporation, the Office of Insurance Regulation of the Financial Services Commission, local government, health insurers, health maintenance organizations, health care providers, families participating in the program, and organizations representing low-income families.
(c) In consultation with the Florida Healthy Kids Corporation and the Department of Children and Family Services, establish a toll-free telephone line to assist families with questions about the program.
(d) Adopt rules necessary to implement outreach activities.
(3) The Agency for Health Care Administration, under the authority granted in s. 409.914(1), shall:
(a) Calculate the premium assistance payment necessary to comply with the premium and cost-sharing limitations specified in s. 409.816. The premium assistance payment for each enrollee in a health insurance plan participating in the Florida Healthy Kids Corporation shall equal the premium approved by the Florida Healthy Kids Corporation and the Office of Insurance Regulation of the Financial Services Commission pursuant to ss. 627.410 and 641.31, less any enrollee's share of the premium established within the limitations specified in s. 409.816. The premium assistance payment for each enrollee in an employer-sponsored health insurance plan approved under ss. 409.810-409.821 shall equal the premium for the plan adjusted for any benchmark benefit plan actuarial equivalent benefit rider approved by the Office of Insurance Regulation pursuant to ss. 627.410 and 641.31, less any enrollee's share of the premium established within the limitations specified in s. 409.816. In calculating the premium assistance payment levels for children with family coverage, the agency shall set the premium assistance payment levels for each child proportionately to the total cost of family coverage.
(b) Make premium assistance payments to health insurance plans on a periodic basis. The agency may use its Medicaid fiscal agent or a contracted third-party administrator in making these payments. The agency may require health insurance plans that participate in the Medikids program or employer-sponsored group health insurance to collect premium payments from an enrollee's family. Participating health insurance plans shall report premium payments collected on behalf of enrollees in the program to the agency in accordance with a schedule established by the agency.
(c) Monitor compliance with quality assurance and access standards developed under s. 409.820 and in accordance with s. 2103(f) of the Social Security Act, 42 U.S.C. s. 1397cc(f).
(d) 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 use the provisions of s. 641.511 to address grievance reporting and resolution requirements.
(e) Approve health benefits coverage for participation in the program, following certification by the Office of Insurance Regulation under subsection (4).
(f) Adopt rules necessary for calculating premium assistance payment levels, making premium assistance payments, monitoring access and quality assurance standards, investigating and resolving complaints and grievances, administering the Medikids program, and approving health benefits coverage.
The agency is designated the lead state agency for Title XXI of the Social Security Act for purposes of receipt of federal funds, for reporting purposes, and for ensuring compliance with federal and state regulations and rules.

(4) The Office of Insurance Regulation shall certify that health benefits coverage plans that seek to provide services under the Florida Kidcare program, except those offered through the Florida Healthy Kids Corporation or the Children's Medical Services Network, meet, exceed, or are actuarially equivalent to the benchmark benefit plan and that health insurance plans will be offered at an approved rate. In determining actuarial equivalence of benefits coverage, the Office of Insurance Regulation and health insurance plans must comply with the requirements of s. 2103 of Title XXI of the Social Security Act. The department shall adopt rules necessary for certifying health benefits coverage plans.
(5) The Florida Healthy Kids Corporation shall retain its functions as authorized in s. 624.91, including eligibility determination for participation in the Healthy Kids program.
(6) The agency, the Department of Health, the Department of Children and Family Services, the Florida Healthy Kids Corporation, and the Office of Insurance Regulation, after consultation with and approval of the Speaker of the House of Representatives and the President of the Senate, are authorized to make program modifications that are necessary to overcome any objections of the United States Department of Health and Human Services to obtain approval of the state's child health insurance plan under Title XXI of the Social Security Act.
History.—ss. 45, 57, ch. 98-288; s. 7, ch. 2000-253; s. 448, ch. 2003-261; s. 22, ch. 2003-405; s. 11, ch. 2004-1; s. 8, ch. 2006-28; s. 3, ch. 2009-55; s. 12, ch. 2009-113.

409.820 Quality assurance and access standards.—
Except for Medicaid, the Department of Health, in consultation with the agency and the Florida Healthy Kids Corporation, shall develop a minimum set of quality assurance and access standards for all program components. The standards must include a process for granting exceptions to specific requirements for quality assurance and access. Compliance with the standards shall be a condition of program participation by health benefits coverage providers. These standards shall comply with the provisions of this chapter and chapter 641 and Title XXI of the Social Security Act.
History.—ss. 47, 57, ch. 98-288; s. 22, ch. 2003-405.

409.821 Florida Kidcare program public records exemption.—
(1) Personal identifying information of a Florida Kidcare program applicant or enrollee, as defined in s. 409.811, held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
(2)(a) Upon request, such information shall be disclosed to:
1. Another governmental entity in the performance of its official duties and responsibilities;
2. The Department of Revenue for purposes of administering the state Title IV-D program;
3. The Florida Health Choices, Inc., for the purpose of administering the program authorized pursuant to s. 408.910; or
4. Any person who has the written consent of the program applicant.
(b) This section does not prohibit an enrollee's legal guardian from obtaining confirmation of coverage, dates of coverage, the name of the enrollee's health plan, and the amount of premium being paid.
(3) This exemption applies to any information identifying a Florida Kidcare program applicant or enrollee held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation before, on, or after the effective date of this exemption.
(4) A knowing and willful violation of this section is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.
History.—s. 1, ch. 98-119; s. 56, ch. 2000-153; ss. 1, 2, ch. 2003-104; s. 35, ch. 2005-39; s. 11, ch. 2005-82; ss. 1, 2, ch. 2008-146; s. 5, ch. 2011-195.

APPENDIX V: REFERENCE FORM

Provide at least three (3) contract references where Respondent has provided similar services. Contracts should either be current or have concluded within the last two (2) years. FHKC will contact these references so Respondent should ensure that information below is current and accurate for purposes of contacting the contracted entity and contract manager.

	1	2	3
Organization:			
Address:			
Types of Services Provided:			
Contract Begin Date:			
Contract End Date:			
If Contract Ended, Reason Ended:			
Area of Contract: (Statewide, County, Regional)			
How Compensated Under Contract: (Per project, retainer, ad hoc, other, explain)			
Annual Contract Value:			
Contact Name for Contracting Entity:			
Contact Information for Contracting Entity:			