
Table of Contents

State/Territory Name: Hqtkf c"

State Plan Amendment (SPA) #: HN/3: /224; -CHIP

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) State Plan Pages



Children and Adults Health Programs Group

March 19, 2021

Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration, State of Florida
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Dear Ms. Kidder:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) FL-18-0029-CHIP, submitted on June 28, 2018, has been approved. FL-18-0029-CHIP implements mental health parity regulations at 42 CFR 457.496 to ensure that treatment limitations and financial requirements applied to mental health and substance use disorder benefits are no more restrictive than those applied to medical/surgical benefits. This SPA has an effective date of October 1, 2017, with the exception of the changes noted below. Through this SPA, Florida conducted a full parity analysis for the Healthy Kids population and requested deemed compliance for the MediKids and Children's Medical Services populations.

Florida Healthy Kids

Section 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), require states to ensure that financial requirements and treatment limitations applied to Mental Health/Substance Use Disorder (MH/SUD) benefits covered under the state child health plan are consistent with the mental health parity requirements of 2705(a) of the Public Health Service Act, in the same manner in which such requirements apply to a group health plan. To the extent that a state provides both M/S and MH/SUD benefits, it must demonstrate that financial requirements and treatment limitations applied to MH/SUD benefits covered under the state child health plan comply with these requirements. Florida demonstrated compliance by providing the necessary assurances and supporting documentation that the state's application of non-quantitative treatment limitations and financial requirements to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act.

MediKids and Children's Medical Services Plan

Section 2103(c)(7)(B) of the Act, as implemented through regulations at 42 CFR 457.496(b), provides that if CHIP coverage includes Early, Periodic Screening, Diagnostic and Treatment (EPSDT) as defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the state plan will be deemed to satisfy parity requirements. Florida has provided the necessary assurances and supporting documentation that EPSDT is covered under Florida's CHIP program and provided in accordance with sections 1905(r) and 1902(a)(43) of the Act.

Page 2 – Ms. Kidder

During our review of this SPA, the Centers for Medicare & Medicaid Services (CMS) identified areas of Florida health plan member handbooks that could be modified to better describe EPSDT coverage. As part of this SPA approval, Florida completed modifications to the MediKids and Children's Medical Services managed care plan member handbooks on February 2, 2019. This update ensures that the member handbooks align with the requirements of 42 CFR 457.496(b), which cross reference to informing and administrative requirements in section 1902(a)(43) of the Act.

This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Your title XXI project officer is Jack Mirabella. They are available to answer questions concerning this amendment and other CHIP-related issues. Their contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-2424
E-mail: jack.mirabella@cms.hhs.gov

If you have any questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed Amy Lutzky/

Amy Lutzky
Deputy Director

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

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

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

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

Beth Kidder, Deputy Secretary for Medicaid Date _____

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

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

Name: Beth Kidder	Position/Title: Deputy Secretary for Medicaid
Name:	Position/Title:
Name:	Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

Effective Date: July 1, 2018
Proposed Implementation Date: July 1, 2018

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

SPA #21 – Proposed Effective Date: September 1, 2011

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

SPA #22 –Effective Date: July 1, 2012

In accordance with our approved tribal consultation process described in Section 2.3-TC, the tribal notification letters were sent to the Seminole and Miccosukee Tribes on June 21, 2012, listing the SPA changes. The letters asked that comments be directed to Gail Hansen at the Agency for Health Care Administration. The letters advised the tribes that no response would be interpreted as they had no comments. No response was received from either tribe.

SPA #23 – Effective Date: October 1, 2012

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

SPA #24 – Effective Date: August 1, 2014

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

Section 6. Coverage Requirements for Children’s Health Insurance

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

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

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

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

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

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

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

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

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

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

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

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

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

under such coverage. (Section 2103(a)(2))

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

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

- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Healthy Kids Benefits Package was grandfathered in.

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

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

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

services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

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

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

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

The Healthy Kids program does not provide EPSDT benefits.

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

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

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

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

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

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

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

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

- 6.1.4.7.** Other. (Describe)

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

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

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

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

- 6.2.1.** Inpatient services (Section 2110(a)(1))
- 6.2.2.** Outpatient services (Section 2110(a)(2))
- 6.2.3.** Physician services (Section 2110(a)(3))
- 6.2.4.** Surgical services (Section 2110(a)(4))
- 6.2.5.** Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6.** Prescription drugs (Section 2110(a)(6))

Healthy Kids: Covers all prescriptions in the same manner in which the Florida Medicaid program provides. Participant is limited to the generic drug unless a generic is not

available, or the prescriber indicates that the brand name is medically necessary

- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

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

- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

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

- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

- 6.2.14. Home and community-based health care services (Section 2110(a)(14))

Healthy Kids: Home health services are limited to skilled nursing services only. The benefit is intended to provide services on a limited, part-time intermittent basis and excludes meals, housekeeping and personal comfort items.

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. Nursing care services (Section 2110(a)(15))

Healthy Kids: Nursing services in Healthy Kids are limited to skilled nursing only.

6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))

6.2.17. Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Children enrolled in MediKids and the CMS Plan receive Medicaid dental benefits from Medicaid-enrolled providers.

Healthy Kids: Healthy Kids enrollees also receive the Medicaid dental benefit package.

See Section 6.2.-D

Effective July 1, 2010, Healthy Kids dental benefits are provided statewide by two (2) commercially licensed dental insurers. The annual dental benefit limit was eliminated to comply with CHIPRA legislation. If a child needs oral surgery due to an accident or injury to the mouth or jaw, this coverage would still be provided under the child's medical services contractor and not the dental contractor.

6.2.18. Vision screenings and services (Section 2110(a)(24))

6.2.19. Hearing screenings and services (Section 2110(a)(24))

6.2.20. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

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

6.2.21. Outpatient substance abuse treatment services (Section 2110(a)(19))

Healthy Kids: Outpatient visits are limited to 40 outpatient days per contract year.

Effective October 1, 2009, the visit limit on outpatient services has been removed.

6.2.22. Case management services (Section 2110(a)(20))

6.2.23. Care coordination services (Section 2110(a)(21))

Care coordination services is limited to CMS Plan Title XXI enrolled children.

6.2.24. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

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

6.2.25. Hospice care (Section 2110(a)(23))

Healthy Kids: Once a family elects hospice care for an enrollee, other services that treat that terminal condition will not be covered.

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.26. EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

The provision of EPSDT benefits only applies to MediKids and CMS Plan. The Healthy Kids program does not provide EPSDT benefits.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.27. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.28. Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.29. Medical transportation (Section 2110(a)(26))

Healthy Kids covers emergency medical transportation only.

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.30. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

Enabling services are provided for the MediKids and CMS Plan populations.

6.2.31. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

For Children's Medical Services network only, additional benefits for early intervention services, respite services, genetic testing, genetic and nutritional counseling, and parent support services may be offered, if such services are determined to be medically necessary.

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

Children enrolled in the MediKids and Children’s Medical Services Network receive the Medicaid dental benefit package, including EPSDT benefits. Children enrolled in Healthy Kids also receive the Medicaid dental benefit package, but do not receive EPSDT benefits.

The services included in the benefits listed above may be limited to services approved through a prior authorization process. Please see Appendix D for information about services that require a prior authorization. The prior authorization requirements are not established based on the dollar value of a service but are designated specialty services or for services that tend to be over-used, abused or need special oversight or care management by the plan. There is a prior authorization exception process in place for emergency situations.

In Appendix D, there are prior authorization guidelines for general dentists to follow when providing endodontic and periodontal procedures. Prior authorizations are required for referrals and treatment provided by Endodontists, Periodontists, Oral Surgeons and Orthodontists. Depending on the plan and the age of the child, prior authorizations may be required for procedures provided by Pediatric Dentists. Routine care provided by General Dentists does not require prior authorization.

Florida Healthy Kids Corporation requires their contracted dental plans to process all prior authorizations requests within fourteen (14) days of the request.

Current Dental Terminology, © 2010 American Dental Association. All rights reserved.

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific - MediKids and CMS Plan
- American Academy of Pediatric Dentistry - Healthy Kids enrollees follow the American Academy of Pediatric Dentistry periodicity schedule.
- Other Nationally recognized periodicity schedule
- Other (description attached)

Florida Healthy Kids requires that the Healthy Kids dental plans include specific standards for the delivery of services, including standards for access to appointments and geographic requirements for primary care and specialty care providers. Plans are also required to submit quarterly claims data on which annual quality measures are scored, including the number of enrollees who received a dental visit and any dental services during the year. Low scores on these measures are often a pre-cursor to network or service issues.

Families contact the KidCare Call Center with concerns when there is immediate access to care issues. Florida Healthy Kids Corporation staff can trouble-shoot these issues as they arise and also tracks them on a long term basis in order to

identify systematic problems. Contract provisions provide for Healthy Kids to send children to any willing provider if the Plan is not able to meet contract standards at the Plan's expense. Corrective action plans can also be implemented when necessary.

Both Healthy Kids dental plans have a grievance process in place for enrollees to dispute any denial of services. These processes have also been vetted by Healthy Kids. The processes include informal resolution of issues, as well as formal procedures for when the other avenues have not provided the family the relief being sought. Both plans also have an expedited process for emergency or urgent issues.

6.2.2-DC Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health

coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS’s contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

- International Classification of Disease (ICD) ICD-10
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines (Describe: _____)
- Other (Describe: _____)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

- Yes
- No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)).

Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

Yes

No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state’s provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

All children covered under the State child health plan.

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

MediKids Program – children ages 1 through 4 years

Children’s Medical Services Managed Care Plan (CMS Plan) – for children ages 1 through 18 years, with special health care needs

The MediKids Program and CMS Plan enrollees receive Medicaid benefits, including EPSDT services.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

- All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

- All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

- All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

- Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

- Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

- EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

The Florida Healthy Kids Program serves children ages 5 through 18 years, but does not offer this population EPSDT benefits. The program does offer comprehensive health benefits and contracts with licensed health plans. The following identified sections apply to the Florida Healthy Kids Program.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

Mental Health and Substance Use Disorder Parity Category Definitions

Inpatient: covered services provided for the medical care and treatment of an enrollee who is admitted as an inpatient to a hospital licensed under Part I of Chapter 395, Florida Statutes, including enrollees admitted as inpatient to a hospital with the expectation of remaining at least overnight and occupying a bed even though the recipient may be discharged or transferred to another hospital and may not use the hospital bed overnight.

- Part I of Chapter 395, Florida Statutes, defines a hospital as any establishment that:
 - Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy
 - Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent, except that a critical access hospital, as defined in s. 408.07, Florida Statutes, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a critical access hospital
 - Excludes any institution conducted by or for the adherents of any well-recognized church or religious denomination that depends exclusively upon prayer or spiritual means to heal, care for, or treat any person.
- Includes “general hospitals” defined as any facility which meets the provisions of the requirements of a “hospital” and which regularly makes its facilities and services available to the general population.
- Includes “specialty hospitals” defined as any facility which meets the provisions of the requirements of a “hospital” and which regularly makes available either:
 - The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population
 - A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders
 - Intensive residential treatment programs for children and adolescents as defined in s. 395.002, Florida Statutes

Outpatient: covered services provided to an enrollee:

- In the outpatient portion of a health facility licensed under Chapter 395, Florida Statutes
- Admitted as outpatient to a health care facility as defined by s. 408.07, Florida Statutes
- At the service location of an office-based provider
- By telemedicine
- Excludes emergency care

Emergency Care: Visits to an emergency room or other licensed facility within the U.S. if needed immediately due to an injury or illness and delay means risk of death or permanent damage to the enrollee’s health, including:

- Services by a qualified provider that are needed to evaluate or stabilize an emergency medical condition
- Emergency transportation required in response to an emergency medical condition situation

Prescription Drugs: Drugs prescribed for the treatment of illness or injury, including those prescribed by an enrollee’s dental provider under Florida Healthy Kids and excluding drugs provided in an inpatient setting or administered in an outpatient setting.

Covered benefits were categorized based on ICD-10.

6.2.3.1.1 MHPAEA The State assures that:

- The State has classified all benefits covered under the State plan into one of the four classifications.
- The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

- Yes
- No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

- The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii)).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

- Aggregate lifetime dollar limit is applied
- Aggregate annual dollar limit is applied
- No dollar limit is applied

There is no aggregate lifetime or annual dollar limits on any mental health or substance disorder benefits for the Healthy Kids population.

Guidance: A monetary coverage limit that applies to all CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

- Yes (Type(s) of limit:
- No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on any mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on any mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all

medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify: _____)

No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state’s methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that

the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

NQTL Analysis Summary and supporting documentation provided as a separate electronic file.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

- The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

- State
- Managed Care entities
- Both
- Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- State
- Managed Care entities
- Both
- Other

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

8.2.1. Premiums:

All Florida KidCare program components, except Medicaid, adhere to the same monthly premium provisions. The maximum monthly premium per household is \$20 beginning with the payment due July 1, 2003, regardless of the number of children in the family. Effective with the premium payment due January 1, 2004, the monthly premium per household is \$15 for families with income less than or equal to 150% of the federal poverty level and \$20 for families with income above 150% to 200% of the federal poverty level. Effective January 1, 2004, for families at or below 150% of the federal poverty level, Florida Healthy Kids is applying \$5.00 credits per month for every month the \$20.00 premium was paid for coverage during August through December 2003.

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

The following table shows the changes in premium levels.

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

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

Families who do not make their monthly premium payments on time will be disenrolled from coverage and will not be eligible for reinstatement for a minimum of 30 days, in accordance with state law.

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

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

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

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

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

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

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

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

Disaster Relief Provisions

At the State's discretion, working collaboratively, and with the agreement of FHKC and/or CMS Plan, the premium due date may be extended or premiums may be waived for a specific period of time for CHIP enrollees who meet income and other eligibility requirements and who reside and/or work in Governor or FEMA declared disaster areas.

8.2.2.

Deductibles:

None of the Florida KidCare components charge deductibles.

8.2.3.

Coinsurance or copayments:

Healthy Kids

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

8.2.4. Other:

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

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

Florida Healthy Kids Co-payments	
Service	Co-payment Amount
Behavioral Health Outpatient Visits	*\$5.00 per visit
Emergency Room, Inappropriate Use	\$10.00 (waived if admitted)
Emergency Transportation	\$10.00 (waived if admitted)
Eyeglasses, Prescription	\$10.00
Office Visits, Primary Care	*\$5.00 per visit
Office Visits, Specialty Care	*\$5.00 per visit
Prescribed Medicine	*\$5.00 per prescription
Therapy Services (PT, OT, ST)	*\$5.00 per session
Hospice and Home Health Services	*\$5.00 per visit
* increases effective October 1, 2003	

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any

differences based on income. (Section 2103(e)(1)(A)) (42 CFR 457.505(b))

Florida KidCare Application

In 1998, the original Florida Healthy Kids application was modified to become the first joint Florida KidCare/Medicaid application. Since then, the application has gone through several modifications and is now known as the Florida KidCare application. It includes necessary information for Title XIX eligibility determination as well as the KidCare components (MediKids, Healthy Kids and the Children's Medical Services Network). Families will be informed through a separate brochure that is attached to the application packet that, except for Medicaid, monthly premium payments are required. Schedules of the co-payments for the Healthy Kids program are also included on the Healthy Kids web page, in member materials produced by the participating Healthy Kids health plans and through correspondence sent to families who have begun the application process.

The Florida KidCare application has undergone significant revisions and was distributed beginning March 17, 2003. The application was field-tested with target audiences and includes additional data fields that were not captured on the previous application.

Effective with the January 1, 2004 change to a two-tiered premium of \$15 and \$20, enrollees received correspondence advising them if their premium changed. The Florida KidCare and Healthy Kids websites were updated to reflect low cost premiums based on family income. The Florida KidCare Information Line also advised families applying that they would be advised of their premium at the time their eligibility is determined.

The KidCare application was revised again in the summer of 2004 in order to address legislative changes with regard to eligibility and verification of income and accessibility to employer-based health insurance coverage.

The Florida KidCare application is reviewed and revised, as necessary, on a regular basis and in order to accommodate legislative and administrative changes to the program. The most recent application revision occurred in 2009 and, as with all major application changes, focus groups were held to review the application for ease of completion and for public input.

Employee Training

The Departments of Health and Children and Families, the Agency for Health Care Administration, and the Florida Healthy Kids Corporation conduct ongoing training sessions for their respective employees to inform them about all of the requirements of the Florida KidCare program, including family cost-sharing and in response to any legislative or administrative change to the program.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing

in its plan: (Section 2103(e))

- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)
- 8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)
- 8.4.3 No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify:)

No

Effective January 1, 2021, there will be no costing sharing for outpatient behavioral health and substance abuse services.

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any

medical/surgical benefits?

Yes

No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

Florida Healthy Kids identified all services to which financial requirements (copayments) apply. Services were categorized into inpatient, outpatient, prescription drugs, and emergency services categories. The \$10 copayment requirement for corrective lenses was removed from the analysis as inapplicable.

Florida Healthy Kids applies the listed copayments to the following services without distinction between whether services are for mental health/substance use disorder services or medical/surgical services. The copayments apply to emergency services, outpatient services and prescription drugs only; preventive office visits do not have a copay.

- Emergency services - \$10
- Outpatient services
 - Preventive care - \$0
 - All other outpatient services - \$5
- Prescription drugs - \$5

No financial requirements apply to inpatient services. Results: Financial requirements applied to mental health/substance use disorder services are the same as the financial requirements applied to medical/surgical services under the Healthy Kids program.

Effective January 1, 2021, there will be no costing sharing for outpatient behavioral health and substance abuse services.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds (“substantially all”) of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))