59G-14.001 Florida Kidcare Dispute Review and Grievance Process.

(1) Purpose. The Florida Kidcare Dispute Review and Grievance Process (Process) is a comprehensive review of disputes relating to eligibility and enrollment for the Title XXI, Children's Health Insurance Program (CHIP), conducted in accordance with Title 42, Code of Federal Regulations (CFR), sections 457.1130-457.1180.

(2) Definitions. The following definitions are applicable to this rule and do not apply to any dispute or grievance processes relating to the Florida Medicaid program.

(a) Adverse action notice – Letter regarding a premium increase, denial of eligibility, suspension or termination of enrollment, or disenrollment for failure to pay the premium.

(b) Complainant – An individual listed on the enrollee's Florida Kidcare account as a parent, caretaker, or an emancipated minor who submits a dispute or grievance.

(c) Dispute – Written request to review an eligibility or enrollment decision received within 90 calendar days of the date of an adverse action notice.

(d) Dispute Review File – Documents collected by the Florida Healthy Kids Corporation or provided by the family during the dispute review process.

(e) Enrollee – Child eligible for and receiving CHIP coverage under the Florida Kidcare Act.

(f) Florida Healthy Kids Corporation (Corporation) – Designated eligibility processor for the CHIP program. The Corporation is also responsible for conducting the dispute review process and preparing all written dispute review responses.

(g) Grievance – Written request to review an eligibility or enrollment decision after the dispute review process has been completed.

(3) Dispute Review Process.

(a) The dispute review process is conducted in accordance with time frames specified in 42 CFR 457.1160.

(b) The dispute review process begins when the Corporation receives a dispute from a complainant. For disputes received within ten calendar days of an adverse action notice, the Corporation will take the following actions when requested by the complainant:

1. Continue or reinstate health coverage retroactive to the first day of the month in which the request for continuation was received.

2. Restore the former premium amount. All premium payments must be paid in a timely manner to maintain coverage during the continuation period.

(c) The Corporation must explain the complainant's liability to repay all premiums and cost of benefits received if the original adverse action decision is upheld.

(d) The Corporation must comply with the following time frames:

1. Send written acknowledgement to the complainant, within three calendar days of receipt of the dispute.

2. Render a written decision within 15 calendar days of receipt of the dispute.

(e) The Corporation may request additional information from the complainant and extend the dispute review period for up to 30 calendar days. Additional information requested by the Corporation must be provided within ten calendar days; if requested information is not provided, the Corporation will render a decision based on the available information.

(f) The complainant will be notified of the decision by the Corporation.

(g) The complainant may appeal the dispute review process decision to the Corporation's Chief Executive Officer (Officer) or designee. The Officer will notify the complainant of the decision in writing within ten calendar days of the complainant's dispute review decision appeal request, and provide information regarding additional appeal rights as described in paragraph (h).

(h) The complainant may appeal the Officer's decision by submitting a grievance request through the Corporation to the Agency for Health Care Administration (AHCA), within ten calendar days of the Officer's decision. The Corporation must forward the grievance request and the dispute review file to AHCA within five calendar days of receipt of the grievance request.

(4) Grievance Process.

(a) The Agency for Health Care Administration will send a letter to the complainant within five calendar days of receiving the grievance request:

1. Acknowledging receipt of the grievance.

2. Requesting additional information, if needed.

3. Instructing how a complainant may request a copy of the dispute review file and appoint a representative.

(b) Complainants must submit any requested additional information to AHCA within 10 calendar days.

(c) The Agency for Health Care Administration will render its final decision in writing based on the available information within 30 calendar days of receiving the grievance request.

(d) MediKids, Healthy Kids, and Title XXI Children's Medical Services Managed Care Plan are bound by AHCA's final decision.

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