FLORIDA HEALTH JUSTICE PROJECT

Advocate's Guide

Florida Long-Term Care Medicaid Waiver

5th Edition

July 2022

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Updated Acknowledgement:

Advocate Guides need to be regularly updated: laws change, rules change, waiver documents are updated, managed care contracts are amended. Thus, we are deeply grateful to Naomi Stanhaus and the RRF Foundation for Aging whose generous support has made regular updating of this *Guide* possible.

We are also deeply grateful to the Alliance for Aging and the RRF Foundation for Aging for supporting production of a video for consumers that is based on the *Guide*.

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Miriam Harmatz, Advocacy Director & Founder, Florida Health Justice Project

Melissa Lipnick, Florida Health Justice Project Equal Justice Works Fellow Sponsored by the Florida Bar Foundation

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Updated Acknowledgement:

Advocate Guides need to be regularly updated: laws change, rules change, waiver documents are updated, managed care contracts are amended. Thus, we are deeply grateful to Naomi Stanhaus and the RRF Foundation for Aging whose generous support has made regular updating of this Guide possible.

Additionally, feedback from providers and consumers informs and improves the entire Guide, including the "Advocate Tips." We are grateful to Alliance for Aging, Inc., the Area Agency on Aging for Miami-Dade and Monroe Counties., whose generous support has enabled us to meet with community providers that serve older residents in need of home based services. We are also deeply grateful to Alliance staff for providing their time and expert input. Along with community providers, their expertise and real life experience has been critical in making the Guide as useful and relevant a tool as possible. We are also very grateful to staff from both the Florida Medicaid Agency and the Florida Department of Elder Affairs who reviewed the Guide and provided essential feedback. As lawyers, we can provide analysis and citations for the multiple sources of authority governing Florida's LTC waiver, but this is no substitute for the day-to-day experience in helping frail and disabled individuals obtain the services needed to remain safely at home. We are also deeply grateful to the Alliance for Aging and the RRF Foundation for Aging for supporting production of a video for consumers that is based on the Guide.

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Miriam Harmatz, Executive Director, Florida Health Justice Project

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Miriam Harmatz, Executive Director, Florida Health Justice Project
Katy DeBriere, Legal Director, Florida Health Justice Project

Section One: Introduction

Why this guide?

It goes without saying that government-subsidized health care benefits are critical for low-income Florida seniors—particularly those who are frail and disabled.

This *Guide* concerns one of the most important health care benefits for this population—the long-term services and supports ("LTSS") that are essential to being able to remain in one's home or community rather than having to receive care in a nursing home. Also known as "home and community-based services," ("HCBS"), these include services not typically available through Medicare or standard medical insurance, such as personal care aides and private duty nursing. Nationwide, over half of people turning 65 will at some point develop a severe disability or medical condition that will require HCBS.[1]

In Florida, HCBS for adults are available under the Statewide Medicaid Managed Care system. Long-term care–including both nursing home care and HCBS–are part of Florida's "Long-Term Care Program."[2] This Guide, however, focuses exclusively on the portion of the LTC Program which provides HCBS, (the "LTC Waiver.") While the LTC Waiver has a cap on the number of individuals served and a wait list for enrollment,[3] that should not deter individuals from applying.

Purpose of the guide

This *Guide* provides advocates with an overview of the authority governing Florida's Medicaid Managed Care Long-term Care (LTC) Waiver and a roadmap addressing basic questions including:

- Who is eligible for the LTC Waiver

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[1] Reinhard et al, *Picking Up The Pace of Change: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers,* Long-Term Services and Supports State Scorecard 2017 Edition, at 5. LTSS scorecard (LTSS State Scorecard: 2017 Ed. AARP et al.) at 5 (about 52% of will at some point develop a severe disability that will require LTSS.) *See also* most recent score card from 2020 ranking Florida 51st for long term services and supports, https://www.longtermscorecard.org/databystate/state?state=FL.

[2] Fla. Stat § 409.979 (1); *see also* § 1915(c) of the Social Security Act authorizing state Medicaid programs to provide home and community-based services, including services that are not strictly medical in nature, for individuals who would otherwise need care in a nursing home or other institution, are authorized under. 42 U.S.C. § 1396n(c); 42 C.F.R. § 440.180(b).

[3] Fla. Stat § 409.979 (3).

- How to apply
- What to do if an application is denied or delayed
- How does the wait list work
- What to do if eligibility is terminated
- What services are covered and how is the "care plan" developed
- How does managed care work
- What to do if services are denied, delayed, terminated or reduced

Section Two: Background

What are Medicaid waivers?

Under waiver programs, states can "waive" certain requirements in the Medicaid Act with permission of the federal government. For example, a waiver program allows states to provide care for people who might not otherwise be eligible under Medicaid; provide services that are not otherwise covered as medical services in the Medicaid Act; or implement a managed care system. Florida's current Long-Term Care Waiver operates through two separate waivers authorized under Social Security Act Sections 1915(b) (for managed care) and 1915(c) (HCBS).

Section 1915(c), authorizing Medicaid HCBS waivers, was enacted by Congress in 1983. HCBS waivers allow states to provide home and community support services to a specified number of individuals as an alternative to institutional care.[4] All individuals enrolled in a HCBS waiver must meet an institutional level of care.[5]

To facilitate these programs, the federal government can waive general Medicaid rules that programs be available throughout a state (referred to as the "statewideness" requirement) and to all eligibility groups (the "comparability requirement"), and also offer more lenient financial eligibility standards.[6] In addition, Section 1915(b) of the Social Security Act provides authority for states to require enrollment in managed care by waiving the Medicaid Act's provision that beneficiaries are free to choose their providers.[7]

Because states are allowed to limit enrollment in HCBS waivers,[8] eligible individuals who meet the clinical and financial eligibility requirements for HCBS can nonetheless be put on a waiting list. By contrast, similarly eligible individuals seeking nursing home placement cannot be put on a wait list.[9]

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[4] § 1915(c) of the Social Security Act, 42 U.S.C. §1396n(c).
[5] Fla. Stat. §409.979(1)(b).
[6] 42 U.S.C. § 1396a(a)(1), (10)(B), (10)(C)(i).
[7] 42 U.S.C. § 1396a(a)(23).
[8] 42 U.S.C. §1396n(c)(9).
[9] Nursing home services, unlike HCBS, are mandatory under federal and state Medicaid statute. 42 U.S.C. § 1396a(a)(10)(A)(i) Fla. Stat. §409.905(8).

HISTORY AND CURRENT STATUS OF FLORIDA'S LONG-TERM CARE WAIVER

In 2011, the Florida Legislature established a statewide integrated managed care program for all covered services, including long-term care.[10] The new statewide program included the "managed medical assistance (MMA) program" for delivery of primary and acute medical assistance, and the long-term care ("LTC") managed care program.[11]

Under a managed care delivery model, the state contracts with private entities, including managed care organizations to "manage" the health care needs of their enrollees using their own network of providers. These managed care organizations (hereafter referred to as the "Plans") act as the gatekeepers for authorization of services and referrals to network providers for covered services.

After a public comment period, the Agency for Health Care Administration (AHCA) submitted two waiver applications to the Center for Medicaid and Medicare Services, (CMS), the federal agency responsible for administering Medicaid. In 2013 CMS granted approval under both to provide HCBS through the Statewide Medicaid Long -Term Care Program. (Hereafter the "LTC Waiver").

In 2016, AHCA requested and received a five (5) year renewal of both the 1915(b) and (c) waivers to continue its LTC Waiver.

In August 2021, AHCA requested another (5) year renewal of both the 1915(b) and 1915(c) waivers[12],[13]

On April 1, 2022, CMS approved the renewal requests, including approval of an annual number of unduplicated recipients of 105,111 for year one (1) of the waiver and increasing each year of the waiver by an average of 2,700, CMS also approved the request for 84,000 as

[10] Fla. Stat. §409.964.

[11] *Id.*

[12] https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915(b)_LTC_Waiver_Renewal_2021.pdf and https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915(c)_LTC_Waiver_Renewal_2021.pdf

[13] Florida Health Justice Project (FHJP) and others submitted comments to the state Medicaid Agency and CMS raising questions and concerns including, e.g. the over-reliance on natural supports, issues with network adequacy, low wages for direct care providers, transparency and accountability.

https://www.floridahealthjustice.org/uploads/1/1/5/5/115598329/_fhjp_final_comments_on_fl_1915_b_c_renewal_sept.16_2021.pdf

number of maximum number of participants served during year 1, increasing by about 2,500 each year thereafter.[14]

This year's enrollment numbers represent an increase of 6,784 and 8,000 (respectively) between year 5 of the previous waiver. [15]

The waiver applications, which contain multiple terms and conditions, are posted online and cited throughout this *Guide*. Advocates should be familiar with these documents, as they provide extensive detail describing how the State will operate the Program.[16]

[14] https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Approved_2022_1915(c)_waiver.pdf at 27.

[15] *Id. see also;* https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915c_Waiver_Amendment_12-17-2020.pdf at 31-32.

[16] Unlike the Section 1115 Waiver authorizing Florida to implement a statewide mandatory managed care system for Medicaid's general medical services, CMS' approval of the LTC waiver requests under section 1915(c) and 1915(b) does not contain any specific agreement between CMS and the State specifying how the state is required to administer the waiver, also referred to as Special Terms and Conditions (STC).

Section Three: Waiver Overview

Different Agencies

Federal law requires each state to administer its Medicaid program through a single state agency.[17] The designated state agency in Florida is the Agency for Health Care Administration (AHCA).[18]

Thus, AHCA is ultimately responsible for ensuring that the LTC Waiver complies with all aspects of federal and state law, including the promulgation of appropriate administrative rules, and development of contracts between AHCA and the Plans that accurately reflect federal and state statutes and regulations.

AHCA administers the waiver in partnership with, the Department of Elder Affairs (DOEA), which maintains the statewide wait list for the LTC Waiver and assists with enrollment. DOEA is also responsible for determining clinical eligibility through its CARES program.[19] The Department of Children and Families (DCF) is responsible for determining financial eligibility.[20]

LTC Waiver Populations

The 2011 Florida statute establishing the statewide integrated managed care program described the populations required to enroll as including beneficiaries needing a nursing home level of care who are: 1) age 18 and older, who are eligible for Medicaid due to blindness or disability or 2) age 65 or older who are eligible for Medicaid based on age.[21]

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[17] 42 U.S.C. §1396a(a)(5); 42 C.F.R. § 431.10.
[18] Fla. Stat. § 409.901(2).

[19] *See* Fla. Stat. § 409.979 (3) for description of DOEA responsibilities in the LTC Waiver; *see also* https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915(b)_LTC_Waiver_Renewal_2021.pdf at 14.
[20] Fla. Stat. § 409.902(1).

[21] Pursuant to Fla. Stat. § 409.979(2)(a), 150 individuals from the Adults with Cystic Fibrosis Waiver transitioned, 468 individuals from the Traumatic Brain and Spinal Cord Injury Waiver transitioned, and approximately 1,100 individuals from the Project AIDS Care Waiver were transitioned into the LTC Waiver. *see also*

Following CMS's approval, enrollees in four existing HCBS waivers were transitioned into the LTC Waiver: (1) the Aged/ Disabled Waiver, (2) the Assisted Living Waiver, (3) the Channeling for the Frail Elderly Waiver, and (4) the Nursing Home Diversion Waiver.

In 2017, state legislation was passed directing AHCA to consolidate three additional adult HCBS waiver populations (Project AIDS Care, Traumatic Brain and Spinal Cord and Adult Cystic Fibrosis) into the Long-term Care (LTC) Waiver. Pursuant to the statute, eligible individuals from each of those waivers were transitioned into the LTC Waiver in January 2018. [22]

Other HCBS Populations and Programs

PACE:

Advocates and consumers should be aware of Programs of All-Inclusive Care for the Elderly ("PACE"). The PACE program, like the LTC Medicaid managed care program, provides an alternative to nursing facility care.

PACE programs establish centers for Medicaid or Medicare recipients to receive services covered by Medicaid and Medicare. Unlike LTC waiver service eligibility, placement in a PACE program includes age-based criteria. To receive PACE services, applicants must: 1) be 55 or older, 2) live in the service area of a PACE organization, 3) need a nursing home-level of care (as certified by the applicant's state), and 4) be able to live safely in the community with help from PACE. [23] Enrollees receive all medical services and prescription drugs covered by Medicare and Medicaid on site of the PACE program. Enrollees also receive transportation, home care, checkups, hospital visits, and nursing home stays when necessary.

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https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915c_Waiver_Amendment_12-17-2020.pdf at 3.

(Note, not all individuals in the PAC waiver were transitioned in the LTC. Only those receiving HCBS who met a nursing facility level of care were transitioned into the LTC. Others maintained Medicaid eligibility through an amendment to the 1115 Managed Medical Assistance Waiver that established financial and non-financial eligibility criteria.)

[22] Fla. Stat. § 409.979(2)(a)*; see also*

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Approved_2022_1915(c)_waiver.pdf at 4.

[23] "Who Can Get PACE?" https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/pace#

For individuals that have both Medicaid and Medicare, PACE program enrollment is fully covered financially. Those who receive only Medicare pay a monthly premium. [24]

ROLE OF THE MANAGED CARE PLAN

As discussed more fully below, all Plans operate under the same Core Contract with AHCA which requires provision of covered services that are "medically necessary" for the individual enrollee. The case manager, the main point of contact between the enrollee, helps develop a "plan of care," and is responsible for providing ongoing assistance in obtaining necessary services.[25]

[24] "PACE" https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/pace.

[25] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 14-16.

Section Four: LTC Waiver eligibility standards

Clinical

In order to meet clinical eligibility, applicants must require a "nursing facility level of care."[26] Determining if the applicant requires nursing facility care (also referred to "the level of care determination") is done by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program. [27]

Financial

Financial eligibility is determined by the Department of Children & Families (DCF) pursuant to SSI-Related Medicaid rules.[28] If an LTC Waiver applicant is already Medicaid-eligible because he or she receives Supplemental Security Income (SSI), or Medicaid based on age or disability (MEDS-AD), DCF does not need a new application.

The 2022 income limit for HCBS waiver programs is 300% of the SSI income limit, or $ 2543 per month for an individual.[29] Applicants for the LTC Waiver whose income is over this amount may still qualify by establishing an income trust that receives the person's "excess" monthly income.[30] The asset limit is $2,000 for an individual and $3,000 for a couple, not including $ 13,000 and $ 24,000 disregards respectively as well certain exempted assets, such as the homestead or a vehicle.[31]

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[26] Fla. Stat § 409.985 (3); Fla. Admin. Code R. 59G-4.192, incorporating by reference the Florida *Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy*, March 2017, (hereafter the LTC Waiver Rule), March 2017 at 3.

[27] Fla. Stat. § 409.985 (1),(3). The Medicaid Agency operates the CARES program thought an inter-agency agreement with the Department of Elder Affairs. § 409.985(2).

[28] Fla. Stat. § 409.902(1); Fla. Admin Code R. 65A-1.712(1)(f); Fla. Admin Code R. 65A-1.713(1)(e).

[29] *https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf (the income limit for a single person is 300% FPL is $2,523; plus a $ 20 disregard.) See also:* Fla. Admin Code R. 65A-1.716(5)(b).

[30] Fla. Admin. Code R. 65A-1.713(1)(e) noting that establishment to an income trust for purposes of qualifying for HCBS must comply with the requirements set forth in Fla. Admin Code R. 65A-1.702(15).

[31] Fla. Admin Code R. 65A-1.716(5)(a); *see also* https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf

Advocate Tip
Financial eligibility is complicated, and this Guide does not attempt to address Medicaid planning for persons whose assets or income exceed the Medicaid limits, or for couples where only one spouse requires LTC Medicaid. These applicants should consult an attorney with expertise in these matters.

Section Five: What is the application process?

Application Steps

Step 1: Make an appointment to be screened for LTC Waiver wait list priority.

For most applicants, the first step is contacting the local Aging & Disability Resource Center (ADRC) or the Elder Helpline at 1-800-96-ELDER (1-800-963-5337). Florida has eleven (11) ADRCs and the contact information for the applicable office can be found at the Department of Elder Affairs website.[32] Relevant contact information for each region is also included in the Appendix.

Advocate Tip
Indicate directly to the ADRC that you want to apply for the LTC Waiver program. Persons with cognitive or communication related disabilities can request a "reasonable modification" such as an in-person assessment. The modification request should be made during the initial call to the ADRC and followed up with a written request.

The Department of Elder Affairs (DOEA) has a handbook on their website that describes the intake, screening, prioritization, assessment, and case management processes.[33]

Some ADRCs will either do an initial assessment, called the 701S, at the time of the call or set an appointment. Other ADRCs will send a letter scheduling a telephone appointment for the initial assessment.

For individuals who are already receiving Older American Act (OAA) services through a community provider, there is also a 701 A assessment. This is an in-person assessment performed by the agency providing the individual's home-based services, such as personal

[32] https://elderaffairs.org/resource-directory/aging-and-disability-resource-centers-adrcs/. (Note there are numerous links in this guide to DOEA forms and materials, the links were functioning as of the date the guide was published. But the authors have noted that the links in the past have changed. Please notify info@floridahealthjustice.org if there are problems with the links or notify DOEA.

[33] https://elderaffairs.org/wp-content/uploads/2020-chapter-2-intake-screening-prioritization-assessment.pdf

care and home delivered meals. [34] The 701A gathers much of the same data items as the 701S and, as with the 701S, the 701A, will result in a priority score. The provider Agency completing the 701A submits it to the ADRC. However, even though the 701A is done in person and produces a priority score, the ADRC is still required to provide a 701S.

Step 2: The 701S Assessment and Waiver Prioritization

The ADRC telephonic assessment of needs uses the 701S Screening Form.[35] This form gives a "priority score" that measures both the applicant's need for assistance as well as what caregiver resources are currently available.[36]

The interviewer will ask for information including: if the applicant lives alone or has a caregiver; the caregiver's health status and ability to continue to provide care; the applicant's present health and how it compares to the prior year; how the applicant's health may limit preferred activities; assistance needed with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)[37]; and health care resources available to the applicant, including access to health care and medications.[38]

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[34] The 701A Condensed Assessment, incorporated by reference in Fla. Admin. Code r. 58A-1.010 is based upon the 701B Comprehensive Assessment. Local programs complete the 701A assessment tool as an eligibility requirement prior to rendering a service that is funded by the local ADRC. It is administered face-to-face to non-case managed clients in local OAA (Older Americans Act) programs, *see,* Department of Elder Affairs, Assessment Forms, Instructions, and Training; (https://elderaffairs.org/wp-content/uploads/701A_Condensed_Assessment.pdf). Currently, the 701A assessment tool does not have an accompanying instructional tool. However, the 701D Instructions, which serve as a guide for completing the 701B assessment tool, can be used as a guide as the 701A is based on the 701B. Department of Elder Affairs, 701D Instructions. (https://elderaffairs.org/wp-content/uploads/701d-assessment-instructions.pdf

[35] https://elderaffairs.org/wp-content/uploads/701S_Screening_Form.pdf

[36] Fla. Stat. § 409.979(3)(a), Fla. Admin. Code R. 59G-4.193(3)(a).

[37] *See* LTC Waiver Rule at 1-2; Sections 1.3.1; 1.3.9 defining ADLs as including, e.g. bathing, dressing, eating, toileting transferring maintaining continence and IADLs as including those activities necessary to allowing the individual to function independently, e.g. grocery shopping, laundry, light paperwork, money management.

[38] *Id.*

Advocate Tip:
Because the 701S form measures both the applicant's need for assistance and the caregiver resources currently available, it is important to underscore exactly what the applicant cannot accomplish independently, be realistic about what a caregiver can actually do, and underscore any questions/concerns about the caretaker's sustainability. It is also important to listen carefully to the question, to answer carefully and to request clarification whenever necessary. [39, 40]

Once the 701S form is completed, the ADRC will calculate the priority score and assign a frailty-based level or category referred to as a "rank."[41] The individual is scored using a matrix.[42] An individual is prioritized for LTC waiver services based on their score and rank:

- Rank 1: 0-15.
- Rank 2: 16-29.
- Rank 3: 30-39.
- Rank 4: 40-45.
- Rank 5: Greater than or equal to 46.

Designated groups who skip steps 1 and 2:

The Florida Legislature in Section 409.979(3)(f) specified three (3) categories of individuals who are entitled to priority enrollment for home and community-based services under the LTC Waiver. [43] Those individuals, described below, do not have to complete the 701S screening assessment or wait-list process if all other LTC program eligibility requirements are met:

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[39] It may be useful to review the training power point provided to interviewers. *See* *https://elderaffairs.org/programs-services/medicaid-long-term-care-services/701s-assessment-training*/

[40] It may be useful to review the 701D form which provides standardized instructions for assessors completing the 701B. *See* https://elderaffairs.org/wp-content/uploads/701d-assessment-instructions.pdf

[41] Fla. Admin. Code R. 59G-4.193(3)

[42] https://elderaffairs.org/wp-content/uploads/DOEA_Priority_Score_Calculation.pdf

[43] Fla. Stat. § 409.979(f).

- An individual who is 18, 19, or 20 years of age who has a chronic debilitating disease or condition of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.[44]

- A nursing facility resident who requests to transition into the community and who has resided in a Florida licensed skilled nursing facility for at least 60 consecutive days.

- An individual who is referred by the Department of Children and Families pursuant to the Adult Protective Services Act, ss. 415.101-415.113, as high risk and who is placed in an assisted living facility temporarily funded by the Department of Children and Families.

The Medicaid rule prioritizes individuals consistent with Section 409.979. Additionally, the rule specifies three (3) categories of individuals listed above the rank of 5.[45] Those include:

- Rank 6: Aging Out Referral (individuals in disability programs who reach the maximum age for those programs).
- Rank 7: Imminent Risk.
- Rank 8: Adult Protective Services High Risk Referral

According to state rule, "imminent risk" is defined as someone who meets the following conditions: unable to perform self-care because of deteriorating mental or physical health condition(s); there is no capable caregiver; and placement in a nursing facility is likely within a month, or very likely within three months.[46]

Advocate Tip:
If an applicant is at imminent risk of being placed in a nursing home, it is important to describe to the 701S assessor in detail how the person meets each prong of the definition.

[44] *See Jones et al. vs. Agency of Health Care Administration (AHCA)*, a case in which AHCA was forced to take comprehensive corrective action after a petition from FHJP and Disability Rights Florida, after improperly denying a 20-year-old Medicaid beneficiary's request to bypass the 55,000-person waitlist to be immediately enrolled into Florida's long term care waiver program. The comprehensive corrective action ensures that medically fragile Medicaid youth do not experience a break in coverage of critical medical services.

[45] Fla. Admin. Code Rule 59G-4.193(3)(b).

[46] Fla. Admin. Code R. 59G-4.193(2)(e).

POST-SCREENING NOTICES

Prior to 2020, the statute provided that after an applicant is screened, written notice, including notice of the right to appeal the screening sore and rank would be sent. As a practical matter, notices varied throughout the state and were not consistently provided.

In 2020 the Florida Legislature amended the law to state that the post-screening notice be sent after completion of screening or rescreening, "**unless the individual has a low priority score**." (emphasis added). "Low score" (also referred to as a "low priority rank") was not defined in the statute.[47]

Following this change in the statute, the Medicaid Agency (AHCA) commenced administrative procedures to promulgate a new rule defining what constitutes a "high or low" score, what would be in the notice to those with a "high score" (or high priority rank), and specifying what notice, if any, would go to individuals with a "low score." [48]

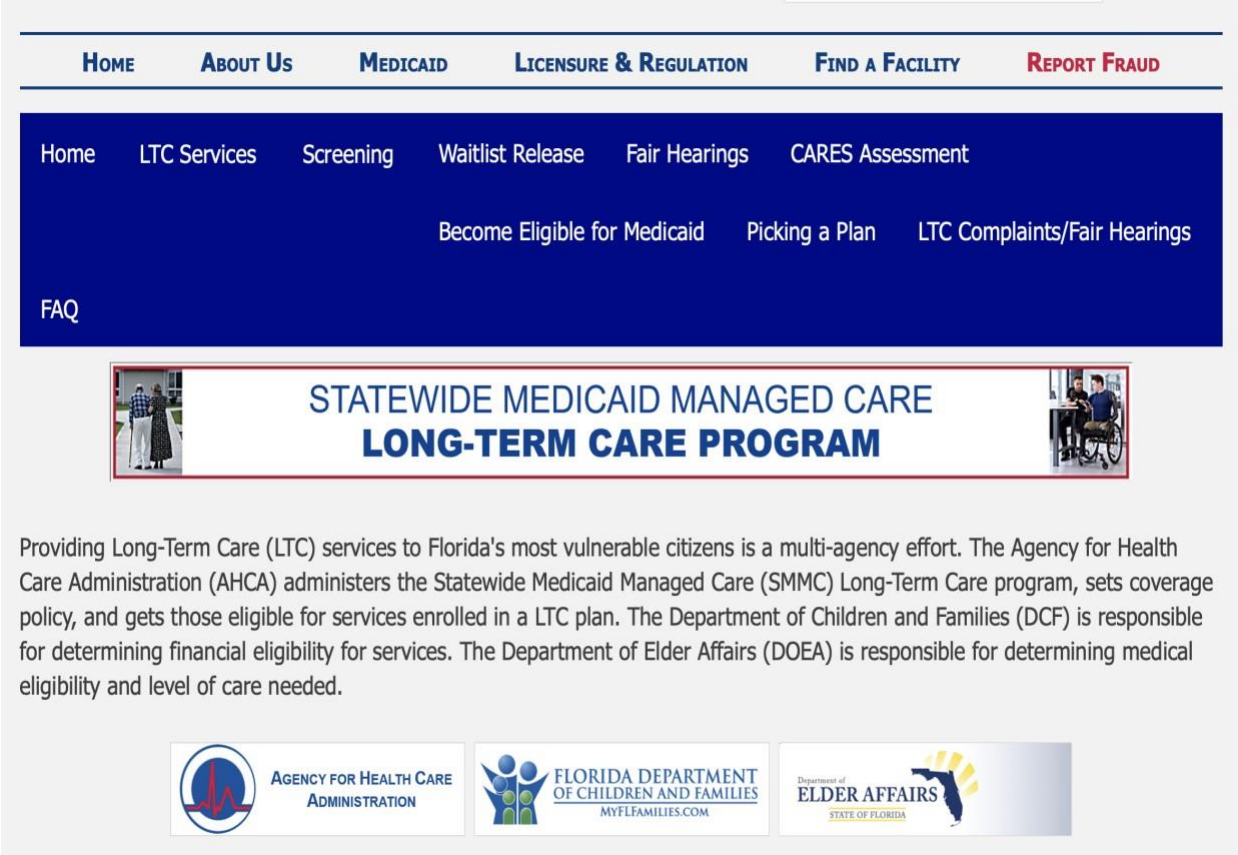
AHCA's new rule defines a "low" priority rank as a 1 or 2, and a "high" priority rank as a 3 or above. In response to public comments by Florida Health Justice Project and others[49], the Agency's final rules provides that everyone who completes the screening process will be sent a written notice, including those with a low score. The notice, from the Department of Elder Affairs (DOEA) would inform the individual of the following:

1. The individual's priority rank
2. Contact information for the Aging & Disability Resource Centers (ADRC)
3. Instructions for requesting an administrative fair hearing
4. Instructions for requesting a copy of the completed screening tool, which includes the priority score; and
5. Instructions for requesting a rescreening. The individual, or their authorized representative, may request a rescreening due to a significant change in condition.
6. For individuals with a high priority rank, notification of wait list placement.

[47] Fl. Stat. 409.979(3)(b)
[48] 59G-4. 193.
[49] *see* FHJP public April 16, 2021 public comment

7. For individuals with a low priority ran, notification of ineligibility for wait list placement and information on how to find community resources available to assist them.

The notice includes a link to a central website where individuals can learn more about the screening process, as well as how to request a copy of their screening results, request a fair hearing, or submit a complaint.



https://ahca.myflorida.com/medicaid/statewide_mc/ltc_scrn_cop.shtml

Step 3: Release from the waitlist and determination of clinical/financial eligibility

The Department of Elder Affairs (DOEA) has an operational manual which details the process by which individuals are released from the wait list and proceed through the eligibility and enrollment process.[50] (hereafter "EMS Manual.")[51]

Pursuant to the EMS Manual, DOEA will notify local ADRCs when waiver slots have been released, and the ADRC then contacts those individuals included in the release list.[52] After confirming that the individual is still in need of long-term care services, the ADRC sends a written notification of wait list release. This notice includes information on the enrollment process and the instructions and timeframes for completing eligibility.[53]

Clinical and financial eligibility

Following release from the wait list, two determinations are necessary: clinical and financial eligibility.[54] The DOEA-administered CARES program determines clinical eligibility[55], and DCF determines financial eligibility[56].

Advocate Tip:

It is important for advocates and provider agencies to know that if an individual applying for LTC is currently getting home health service through the Community Care for the Elderly (CCE) program and the individual is released from the wait-list but fails to complete an application or does not meet financial eligibility, and is thus denied, the individual may not be able to get back on CCE right away.

[50] Fla. Stat. § 409.979(3)(d), *see also* the DOEA "*Statewide Medicaid Managed Care Long-term Care Program Enrollment Management System Procedures Manual"* for a detailed description of the process by which individuals are released from the wait list and the eligibility and enrollment process. The most recent Manual on DOEA's website from 2013. https://elderaffairs.org/wp-content/uploads/smmc-ltc-enrollment-management-system-procedures.pdf. Pursuant to a 2020 public records request, the authors of this Guide were provided with the updated and expanded Enrollment Management System (EMS) Procedures Manual currently in use dated September 2018. This Manual is available on the Florida Health Justice Website https://www.floridahealthjustice.org/uploads/1/1/5/5/115598329/smmc_ltc_ems_procedures_09.06.18_update.pdf. (Hereafter "EMS Manual")

[51] *Id.* at 14.

[52] *Id.* at 15.

[53] *Id.* at 14-17.

[54] Fla. Admin. Code R. 59G-4.1939(g), *see also,* EMS Manual at 15-24.

[55] Fla. Stat. § 409.985, Fla. Admin. Code R. 59G-4.180, 59G-4.290.

[56] Fla. Stat. § 409.902(2), Fla. Admin. Code R. 65A-1.205.

Clinical eligibility

Applicants must have their physician, or other licensed healthcare provider familiar with their needs, complete an AHCA Medical Certification for Medicaid LTC (also referred to as Form 5000-3008)[57] within 30 days from the date of the wait list notification.[58]

As soon as the ADRC receives a complete and correct Form 5000-3008, they will contact the CARES office and request a Level of Care (LOC) determination. [59]

The CARES team will then meet with the applicant and complete a 701B comprehensive assessment.[60] This assessment is administered in a face-to-face meeting by a licensed healthcare provider to ensure the applicant meets the "medical eligibility" for the LTC Waiver.[61] For those applicants who meet the nursing home level of care requirement, the CARES team assigns the applicant into one of three (3) levels[62]:

Level of care 1: applicants residing in, or who must be placed in, a nursing facility.

Level of care 2: applicants at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, and who require extensive health-related care and services because of mental or physical incapacitation.

Level of care 3: applicants at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, who have a limited need for health-related care and services and are mildly medically or physically incapacitated.

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[57] Fla. Admin. Code R. 59G-1.045(4), *see also, https://elderaffairs.org/programs-services/comprehensive-assessment-and-review-for-long-term-care-services-cares/notices-and-forms-used-by-cares-including-ahca-form-5000-3008/*

[58] EMS Manual at 19.

[59] *Id.* at 21.

[60] Fla. Admin. Code R. 59G-4.193(g); Fla. Admin. Code R. 58A-(1)(b).

[61] LTC Waiver Rule at Section 1.3.5; *see* also, https://elderaffairs.org/wp-content/uploads/florida-department-of-elder-affairs-701b-comprehensive-assessment.pdf

[62] Fla. Stat. § 409.985(3), § 409.983(4).

Financial eligibility

Once the Level of Care is determined, the application is forwarded to the Department of Children & Families for completion of eligibility for the LTC waiver.[63] Financial and clinical eligibility determinations can, and should, proceed simultaneously.
The applicant has 35 days from the date of wait list notification to submit the Medicaid application. A Medicaid application submitted through DCF's online ACCESS portal triggers the financial determination.

The ACCESS application asks for the applicant's name, SSN, date of birth, address, phone number as well as income and assets. DCF may also require verification of the applicant's income and assets, e.g., bank statements, pay stubs, and paperwork on asset ownership or recent sales. [64]

Advocate Tip:
Do not wait until all financial eligibility verification is obtained in order to submit the ACCESS application.

[63] EMS Manual at 23.

[64] https://dcf-access.dcf.state.fl.us/access/scrflhomepage.do?performAction=changeLocale&language=english *See also*, Florida Department of Children and Families, Program Policy Manual https://www.myflfamilies.com/service-programs/access/program-policy-manual.shtml at §§ 1640.0000, 1840.0000.

SECTION SIX: WHAT IF APPLICATION IS DENIED OR DELAYED?

INITIAL ASSESSMENT/PRIORITY RANK AFTER RELEASE FROM WAITING LIST

As discussed, after release from the wait list, individuals must be found to meet both clinical and financial eligibility. If the CARES assessment determines that the clinical eligibility has not been met, and the individual wishes to appeal, an appeal should be filed with both the Medicaid Agency and the Department of Elder Affairs.[65]

If the individual is found ineligible based on the financial assessment done by DCF, DCF will send a final notice of case action, and an appeal should be filed with the DCF hearing office.[66]

[65] There is no current authority in either state statute or rule (or in the EMS Manual) addressing notice and right to appeal if an individual released from the wait list is determined not to meet the requisite level of care. Thus, it would be prudent to appeal to both DOEA and the Agency for Health care. The authors have requested clarification.

[66] Fla. Stat. 409.902(1); Appeal Hearings Section,1317 Winewood Blvd. Building 5, Room 255, Tallahassee, FL 32399-0700, Phone 850-488-1429 | Fax 850-487-0662, appeal.hearings@myflfamilies.com.

Section Seven: Plan Enrollment

Picking a plan

An applicant who is found eligible and enrolled in the LTC Waiver must select one of the private managed care plans ("Plans") operating in the region where the applicant resides.

As of the 2018 State Medicaid Managed Care re-procurement process, there are no longer stand-alone long-term care (LTC) plans. Recipients who are eligible for LTC services will choose between either an LTC+ or Comprehensive Plan in their region. Recipients who are eligible for MMA and LTC programs must choose one health plan for all of their services. [67]

The LTC+ Plans provide managed medical assistance (MMA) services and long-term care services to recipients enrolled in the LTC programs. These plans cannot provide services to recipients who are only eligible for regular MMA services. The Comprehensive Plans provide both MMA and LTC services to eligible recipients. [68]

AHCA publishes a "Snapshot" informational brochure for both LTC managed care and for MMA managed care that sets out the types of plans, the Regions and the available Plans in each region. [69]

Each of Florida's eleven regions must have at least two managed care plans to choose from for long-term care services. A list of Plans in each region is also available online or at the local ARDC.[70]

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[67] http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Overview_12042018.pdf at 35; *see also* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf. Note also that as of the publication date of this 5th edition of the Guide, the state is currently engaged in another procurement process. *See* https://ahca.myflorida.com/procurements/index.shtml. *See also*, FHJP comments, https://www.floridahealthjustice.org/uploads/1/1/5/5/115598329/rfi__re-procurement_response_fhjp.pdf.

[68] http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Overview_12042018.pdf at 37.

[69] https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf.; *see also*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Overview_12042018.pdf at 26 and 27.

[70] *See* link for list of ADRCs and contact information: https://elderaffairs.org/resource-directory/aging-and-disability-resource-centers-adrcs/

The enrollee should look at the Choice Counseling website

at www.flmedicaidmanagedcare.com; or call 1-877-711-3662 to talk to a choice counselor. An enrollee can also request that a choice counselor meet with him or her at home.

Enrollees who do not voluntarily select a Plan will be auto-assigned by AHCA. The Agency can only assign Plans that meet or exceed performance standards and must take into account several factors including: network capacity; past relationship between the recipient and the provider; and geographic accessibility.[71]

After selecting a Plan (or being assigned), the Plan will conduct an initial visit. The requirements of the initial visit are enumerated in the Contract between AHCA and the LTC Plans and include explaining the enrollee's rights and responsibilities and finalizing the plan of care.[72]

[71] Fl. Stat. § 409.984(1)(2).

[72] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 15 to 17.

Section Eight: Changing plans/disenrolling

Recipients may request disenrollment at any time via written or oral request to AHCA. Disenrollment for any reason is permitted within the first 120 days after enrollment.[73]

After 120 days, recipients may change plans only for "good cause" or during the annual open enrollment period.

To change their Plan, beneficiaries can speak with a choice counselor at 1-877-711-3662.

"Good Cause"

Pursuant to the state's current rule, the following reasons constitute good cause for disenrollment and do not require that the enrollee first seek resolution through the plan's internal grievance process:

- A substantiated marketing violation has occurred.
- The enrollee has an active relationship (has received services from the provider within the six months preceding the disenrollment request) with a provider who is not on the Plan's panel but is on the panel of another Plan.
- The enrollee needs related services to be performed concurrently, but not all related services are available within the Plan network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
- The Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- Immediate risk of permanent damage to the enrollee's health is alleged.

The following also constitute reasons for good cause disenrollment, however the enrollee must first seek resolution with the plan:

- Poor quality of care.
- Lack of access to services covered under the Contract.
- Lack of access to providers experienced in dealing with the enrollee's health care needs.

[73] The Florida Medicaid Agency (AHCA) has confirmed that beneficiaries are allowed 120 days to disenroll for any reason, notwithstanding that the Florida statute and federal regulation specify a 90-day period. (email confirmation from AHCA available from Florida Health Justice Project.)

- Enrollee needs related services concurrently but not all related services are in the Plan's network and either the PCP or another provider determined that receiving the services separately would subject the enrollee to unnecessary risk.[74]

EXEMPTIONS FROM THE LTC WAIVER

The state allows otherwise mandatory enrollees to request exemption on a case-by-case basis. As with a request for disenrollment (see discussion above), the enrollee should contact the enrollment broker who, in this case, would refer the request to AHCA. If the issue still cannot be resolved after working with the individual and the available LTC plans in the area, the agency has the ability to instruct the enrollment broker to exempt the individual from enrollment into LTC.[75]

[74] Fla. Admin. Code R. 59G-8.600(b). *See also* Fla. Stat. § 409.969(2), providing that "the Agency may require a recipient to use the plan's grievance process before the agency's determination of good cause…" the Agency has implemented this requirement in the rule, *see* Fla. Admin. Code R. 59G-8.600(b). *see also,* https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915(b)_LTC_Waiver.pdf at 33; *see also* https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915(b)_LTC_Waiver_Renewal_2021.pdf at 34; 42 C.F.R. § 438.56. Notably, Florida's Medicaid Agency provides for a larger time frame (120 days) than the amount required under federal law (90 days).

[75] https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915(b)_LTC_Waiver_Renewal_2021.pdf at 34-36.

Section Nine: Care planning

Initial Contact

Once enrolled, the Plan must conduct a face-to-face visit with the enrollee within five business days.[76]

Going over the Handbook

During the initial face-to-face visit, the plan representative provides the enrollee with the Plan's ID card, a provider directory, and an enrollee handbook.[77]

Pursuant to federal regulations the state Medicaid Agency has developed a model enrollee handbook that addresses provisions including:

- the services (also referred to as "benefits") that are provided by the MCO including the amount and length of time that the services are provided;
- how to get the services provided by the MCO, including any procedures needed for obtaining approval of a prescribed service;
- how and where to get any services provided by the State;
- how transportation is provided;
- what emergency services are provided and how to get emergency services;
- information about which providers you can go to, including if/when you can go to a provider who is not in your MCO's network (the word "network" refers to those providers who have signed up with the MCO to provide services to the MCO's enrollees);
- the process for filing grievances when you are unhappy with your MCO;
- the difference between a grievance and an appeal;
- the process for filing an appeal when you don't agree with a decision made by the MCO to deny, reduce or end a service, and the requirement (with some exceptions)

[76] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 15.

[77] *See* 42 C.F.R. 438.10(g) requiring that the handbook explain key elements of how to effectively use the managed care program.

that your appeal must first go to the MCO before you appeal to the state Medicaid Agency;

- the right to continued services pending the outcome of an appeal if services are reduced or terminated;
- the right to a fair hearing with the Florida Medicaid Agency (AHCA) if the MCO does not grant your appeal.[78]

Explaining grievance and appeal

At the initial visit the plan shall review the enrollee's rights and responsibilities, including procedures for filing a grievance, appeal, and or Medicaid Fair Hearing.[79]

Conducting an assessment & developing care plan

Finally, the plan is required to conduct a comprehensive assessment and develop the person-centered care plan of care (discussed below) at the initial meeting.[80]

PERSON-CENTERED PLANNING PROCESS

After years of advocacy, CMS finalized rules in 2014 detailing requirements for "person-centered" planning for all HCBS programs.[81]

"Person-centered" planning means that the process should actually directed by the individual to the "maximum extent possible." [82]

[78] 42 C.F.R. 438.10(g); *See also Enrollee Handbook Template for Enrollees with MMA and LTC Benefits* https://ahca.myflorida.com/Medicaid/statewide_mc/app_contract_materials.shtml

[79] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 15.

[80] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 15.

[81] *See generally,* Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Bases Services (HCBS), 79 Fed. Reg. 2948, 303-31 (Jan 16, 2014)(codified at 42 C.F.R. § 441.301(c)).

[82] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 17.

The process is intended to identify the individual's strengths, capacities, preferences, needs, and desired measurable outcomes. Enrollees are encouraged to make decisions about service options and identify personal goals. They must also be allowed to invite anyone of his/ her choosing to participate in the process and provide aid as needed or desired.[83]

Person-Centered Plan of Care

Pursuant to this planning process, Plans are required to develop a person-centered service plan.[84] This is a written document that reflects the clinical and support needs identified through the assessment process, the person-centered goals and objectives, the services and supports (paid and unpaid) that will assist the enrollee in achieving identified goals, and the service providers. [85]

Additionally, the plan must reflect an enrollee's risk factors and identify measures in place to minimize them, such as individualized backup plans and strategies when needed.[86]

Significantly, the enrollee or enrollee's authorized representative must indicate whether they agree or disagree with each service authorization and review and sign the plan of care at initial development, annual review, and for any changes in services[87]In addition, all individuals and providers responsible for its implementation have to sign the care plan. [88]

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[83] 42 C.F.R. § 441.301(c)(1);
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 18.

[84] 42 C.F.R. § 441.301(c)(2).

[85] 42 C.F.R. § 441.301(c)(2);
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 18-19.; *see also,* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf

[86] 42 CFR § 441.301(C)(2)(vi).

[87] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 19, Sec. VI(E)(5)(b)(4), 19; *see also* 42 C.F.R. § 441.301(c)(2)(ix); 42 C.F.R. 441.301(c)(3).

[88] 42 C.F.R. § 441.301(c)(2)(ix); requires that providers responsible for implementing care plan must sign the plan. *See also* 2022 contract requiring: The Managed Care Plan shall ensure that a copy of the enrollee's plan of care is forwarded within ten (10) business days of initial development or any subsequent updates, to the enrollee's primary care provider and, if applicable, to the facility where the enrollee resides. The primary care provider shall be advised, in writing, of whom to contact with questions regarding the adequacy of the plan of care.

In sum, the Plan of Care (or Care Plan) is the critical written document that specifies the services and supports that are to be furnished in order to meet the enrollee's abilities, needs and preferences, e.g., to live in her/his home.[89]

Advocate Tip:
Advocates should ensure that enrollees receive a legible copy of the Care Plan to review before signing. If an enrollee (or his or her authorized representative) disagrees with any part of the care plan and efforts to resolve with the case manager are not successful, an appeal should be filed. [90]

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 19. Sec. VI(E)(5)(b)

[89] 42 CFR § 441.301(C)(2); *see also*

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 20.

[90] Language regarding the right to written notice and appeal of the Plan of Care per se is not entirely consistent *vis a viz* the Rule, the current Contract and the 1915c application. The Contract requires that the Plan of Care include indication by the enrollee or the enrollee's representative that they agree or disagree with each service authorization and review and sign the plan. Section VI. (E)(5)(b)(4) https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 19. The LTC Rule requires that the Plan of Care be reviewed with the enrollee and include a statement preceding the enrollee's signature attesting that the plan of care has been discussed with and agreed to by the enrollee, and the enrollee understands he/she has the right to request a Fair Hearing *if services are denied or reduced,*" The Florida 1915(c) Waiver application unambiguously provides for the right to written notice and an appeal if the enrollee wishes to challenge any part of the care plan. "**If the enrollee disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the participant with a written notice of action that explains the enrollee's right to file an appeal. The case manager assists the enrollee with filing for an appeal.**"https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Approved_2022_1915(c)_waiver.pdf at 183.

Supplemental Assessment

As part of the comprehensive assessment, the Plans are required to complete a written LTC Supplemental Assessment, and all completed forms should be maintained in the client's case file. [91] (A sample form is included in the Appendix.)

In addition to including the amount of time the enrollee can be safely left alone, the assessment must include the following with regard to natural supports:

- The role of each natural support in the enrollee's day-to-day life;
- Each natural support's day-to-day responsibilities, including an evaluation of the support's work, school, and other schedules and responsibilities in addition to caring for the enrollee
- Each natural support's stress and well-being, including any medical limitation or disability the natural support may have that would limit their ability to participate in the care of an enrollee (e.g., lifting restrictions, developmental disorder, bed rest for pregnancy, etc.)
- The willingness of the natural support to participate in the enrollee's care.

Advocate Tip:
If there is any concern about the sufficiency of services being authorized, a copy of the LTC Supplemental Assessment should be requested from the case manager or the Plan's grievance and appeals coordinator.

Role of Case Management

Effective case management is a critical part of the LTC Waiver, and Section E of the Contract ("Care Coordination/Case Management) specifies a number of case management duties and time frames for contact with enrollees. [92]

[91] LTC Waiver Rule at 8, Section 6.2.1.

[92] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 14-23. **E**23. *See also* 1915(c) Waiver Application at 151-5; C.F.R. § 438.208.

For example, there must be a face-to-face visit within five (5) business days. In addition, the case manager is required to meet with the enrollee at least every 90-days (and more frequently if there has been any significant change).[93]

The previous contract had a specific requirement that the Managed Care Plan follow up within seven (7) days after the initial meeting, to ensure that services specified in the plan of care actually started. Unfortunately, that specific requirement is no longer required on an individual basis. Rather, the current contract requirement is that the Managed Care Plan start services for all in-home HCBS, for eighty-five percent (85%) of the applicable population within seven (7) days of the initial face-to face visit. The timeframe for "starting services" is measured by the number of days between the day of the initial face-to-face visit and the day on which all approved services are rendered or the first of the initial enrollment month, whichever is later.[94]

The case manager is also responsible for ongoing assistance, including assistance in identifying issues and barriers to the achievement of goals and documenting actions taken to resolve issues as quickly as possible. [95]

REASSESSMENT

Managed Care Plans must conduct an annual reassessment of the enrollee's plan of care to determine whether an enrollee's service needs are being met. Reassessment may be conducted more frequently if the need arises. The Plan shall complete the reassessment using Agency-required forms and the plan-developed LTC Supplemental Assessment form.[96]

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[93] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 15 and 21.

[94] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 24. It is important to note that there is still liability for failing to follow up within seven (7) days in Section XIV, Liquidated Damages. *See* 72, No. 9.

[95] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 21.

[96] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 16; LTC Waiver Rule at 8, Sec. 6.2.1. *See* Appendix D for sample Supplemental Assessment Form. Note: the attached sample is not from a current plan; the authors are in the process of obtaining a sample form from a current plan.

PARTICIPANT DIRECTED SERVICES

During the care planning process, enrollees who live in their own home or the home of a family member, can choose to "self-direct" certain waiver services, including adult companion, homemaker, attendant care (private duty nursing), intermittent and skilled nursing, and personal care.

Participants who opt to self-direct these services are then responsible for training workers, setting work schedules, and submitting timesheets to the plan.[97] They do not set the pay rate, however.

Florida's 1915(c) waiver application reflected the State's goals for the number of participants selecting "self-direction" as starting at 10,511 in Year 1 and increasing to 11.599 by year 5 of the waiver. [98]

[97] Application for 1915(c) HCBS Waiver: FL.0962.R01.00 - Jul 01, 2016 pg. 174

[98] https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Approved_2022_1915(c)_waiver.pdf at 219.

SECTION TEN: WHAT SERVICES ARE COVERED?

The Florida Legislature has specified the minimum services that LTC Plans must provide. The state contract requires that MCO Plans also include four (4) additional services: adult companion care; attendant nursing care; assistive care and homemaker. [99]

A complete list of the services is included in the Appendix, and each service is also briefly described in the LTC Rule.[100]
Plans must offer all listed services. None of these services has a limit or cap, beyond the requirement that the service be "medically necessary."

[99] Fla. Stat. § 409.98, https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 8-9. *See also* Snapshot, Appendix B.
[100] LTC Waiver Rule at 4-8.

SECTION ELEVEN: WHEN MUST COVERED SERVICES BE PROVIDED?

Medical Necessity

In determining if a covered service must be provided to an individual beneficiary (including the amount, e.g., physical therapy twice a week), the service must be "medically necessary." There is, however, no definition of "medical necessity" in federal law for adults, including for HCBS services. Rather, the applicable federal regulation simply provides that the service must be sufficient in "amount, duration, and scope to achieve its purpose,"[101] and states have significant flexibility in setting amount, duration, and scope standards. [102] As a result of litigation,[103] Florida's LTC Waiver now has two standards for determining "medical necessity"—one for HCBS services, and one for "mixed services."[104] The "mixed service" standard, also applies to all other services covered in the Medicaid program, e.g., hospitalization. Both standards are set forth in the boxes below.

[101] 42 C.F.R. § 440.230.

[102] *See Alexander v. Choate*, 469 U.S. 287 (1985)(holding that Tennessee could "reasonably" limit coverage of inpatient hospital days per year to 11); *Curtis v. Taylor*, 648 F. 2d 946 (5th circ. 1980) (holding that Florida's rule limiting physician visits to 3/month did not violate federal Medicaid law.)

[103] Florida changed the definition rule for LTC supportive services following settlement of a statewide class action, *Parrales et al. v. Dudek/Senior,* N.D. F. 4:15-cv-424-RH/CAS, brought on behalf Plaintiffs enrolled in the LTC waiver who were unable to obtain necessary services.

[104] The LTC Waiver Rule defines mixed services as "services that covered in both the LTC and the Managed Medical Assistance programs. When covered by both the enrollee's LTC and MMA plans, such services are the responsibility of the LTC plan." LTC Waiver Rule at Section 1.3.15.

Medical Necessity Definition for HCBS:
Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide and; Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. And, one of the following: Enable the enrollee to maintain or regain functional capacity; or Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice. [105]

Under the revised rule for "Home and Community-Based, Supportive Services" e.g., adult companion care, adult day care, and homemaker services, "medical necessity" is defined more liberally to acknowledge use of services to meet functional needs and access to the community.

For "mixed services" (which include all types of nursing care, personal care, and all therapies), the long-standing definition of medical necessity remains applicable.

[105] Fla. Admin. Code R. 59G-4.192, incorporating by reference the "Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy, March 2017, (hereafter the LTC Waiver Rule) at Section 1.3.5.

Florida's General Definition of Medical Necessity, Including for "Mixed Services"[106]

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

1) Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3) Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide and;
5) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Other Coverage Criteria

The LTC Waiver Rule begins with a statement of the overarching goal, i.e., that Plans "*provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization*."[107]

This goal is reflected in specific criteria for coverage, which requires that plans cover services "intended to enable the enrollee to reside in the most appropriate and least restrictive setting," [108] and in the requirement for a "Supplemental Assessment."[109]

As previously discussed, the LTC Supplement Assessment, a key factor in deciding the array of necessary services, must quantify the amount of time an enrollee may safely be left alone and the amount of time a voluntary caregiver is willing/able to provide care. If the enrollee can never be

[106] Fla. Admin. Code R. 59G-1.010, *Definitions Policy,* section 2.83 at 7.
[107] LTC Waiver Rule at 1, § 1.1.
[108] LTC Waiver Rule at 4, §§ 4.2.
[109] LTC Waiver Rule at 8, § 6.2.1.

safely left alone and the caregiver works 40 hours a week, an authorization of only 15 hours a week of direct staffing should be challenged.

Accordingly, in addition to the requirements of the LTC Supplemental Assessment, the Contract also prevents the Plans from ignoring the limitations of an enrollee's natural support system. Specifically, the Contract's provisions on "Service Authorizations" state that the Plan "*shall not deny authorization for a service solely because a caregiver is at work or is unable to participate in the enrollee's care because of their own medical, physical or cognitive impairments*. "[110]

The Contract also mandates that Plans "shall not deny medically necessary services required for the enrollee to safely remain in the community because of cost."[111]

[110] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 24, G(1)(h)

[111] *Id.*

SECTION TWELVE: WHAT ARE THE STANDARDS FOR ACCESS AND CONTINUED COVERAGE?

TIMELY ACCESS STANDARDS

In order to ensure that Plans provide timely access to services, AHCA is required to establish network adequacy standards for the Plans, e.g., the number of providers in each county.[112] These requirements, along with the time standards for travel are set forth in the contract between each Plan and AHCA.

For most LTC benefits, the AHCA/LTC Plan Contract requires that Plans have at least two providers in each county.[113] For those services in which the beneficiary is traveling to the provider, e.g., adult day care or therapy (physical, occupational, respiratory), the travel time maximum is 30 minutes in urban counties and 60 minutes in rural counties.[114] Thus, if an individual in Miami Dade County needs physical therapy three times per week and the travel time to a network provider is an hour, the Plan has violated this standard. If the issue cannot be resolved, the recipient has a basis for a good cause disenrollment. *See* Section, Eight, *supra*.

The Core Contract (which governs both MMA, LTC+, and Comprehensive plans) also requires that Plans have sufficient provider contracts to ensure that medically necessary services can be provided with "reasonable promptness" as set forth in the Medicaid Statute. [115]

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[112] Fla. Stat. §§ 409.982(4); *see also* 42 C.F.R . §438.68.

[113] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 32-35.

[114] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 32-35. *See also,* 42 C.F.R. §438.206.

[115] The Core Contract cites to the "reasonable promptness" requirement in the federal Medicaid statute at 42 U.S.C. 1396a(a)(8). https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 92. However, in contrast to the time standards for determining eligibility (45 days for eligibility not dependent upon disability determination; 90 days for determination based on disability), the federal law does not provide numeric standards for what constitutes "reasonable promptness" for services. Thus, disputes have arisen over what is "reasonably prompt" for different services. *See, e.g. Doe 1-3 ex rel. Doe Sr. 1-13 v. Chiles*, 136 F. 3d 709(11th Circ. 1998) (finding reasonable promptness provision at 1396a(a)(8) enforceable and requiring state to establish reasonable waiting list time, not to exceed 90 days for individuals eligible for IXCF/MR care.)

The LTC Contract's network adequacy standards are in Table 1, which requires that there be two providers in each county for most services, and for services that are provided outside of the home, there is a travel time standard of 30 minutes for urban counties and 60 minutes for rural counties.[116]

Care coordination and continuity

Florida's LTC contract requires that the MCO have a process for "*immediately reporting any unplanned gaps in service delivery.*" As part of this process, the Plan must prepare a "*Service Gap Contingency and Back-Up Plan*" for enrollees who receive services in their home. A "gap" is the difference between the number of hours required by the care plan, and the number of hours actually provided. [117]

The contingency plan must inform the enrollee (or authorized representative) of resources available, including on-call back-up service providers and the "enrollee's informal support system" in the event of an unforeseeable gap, such as a service provider illness or transportation failure.

The "informal support system" is not the "primary source" for addressing a gap, unless that is the enrollee's choice. The MCO must ensure that gap services are provided within a three-hour time frame. The MCO must discuss the contingency plan with the enrollee, provide a copy to her/him, and ensure that the plan is updated quarterly.[118]

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[116] The Current Contract requires that enrollees receive medically necessary services "with reasonable promptness (within the meaning of that term as set forth in 42 U.S.C. §1396a(a)(8))." https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 92. The Prior Contract's Network Adequacy Standards (Section VI) required that plans "provide authorized HCBS within the timeframes specified in Section V, Covered Services." In turn, Section V required plans to ensure services are started within fourteen (14) days after the plan of care is developed and that the plan of care is developed at the initial meeting (within 5 days of enrollment); thus, in the prior contract there was a requirement that enrollees should begin receiving medically necessary services within 19 days of enrollment.

[117] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 12-13, *see also* 2016 federal regulations which were broadened to ensure that enrollees have access to ongoing sources of all appropriate care, including LTSS. 42 C.F.R. 438.208 (b).

[118] *Id.*

LTC plans are also required to include "distinct procedures" in their Utilization Management Program that include "protocols for ensuring that there are not gaps in service authorization for enrollees requiring ongoing services." [119]

Advocate Tip:
Under the contract, the managed care plan must ensure that gap services are provided within 3 hours. If the managed care company is unable to provide an aide the enrollee is entitled to get an aide from another provider, even if it's not their contracted provider.

Additionally, in order to help ensure that enrollees do not experience gaps in critical LTC services, Plans are required to authorize "maintenance therapies" i.e. treatments that are supportive rather than corrective and that prevent further deterioration[120] for no less than six (6) months. For services of shorter duration, authorization must be supported by PCP prescription. If no prescription is required, the decision must be "supported by objective evidence-based criteria." [121]

Advocate Tip:
Because physicians may be unaware of this "maintenance therapy" policy and the ability to write prescriptions for at least 6 months for long term care conditions, it can be helpful to provide the physician's office with a copy of this contract provision.

[119] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 24-26.

[120] LTC Waiver Rule at 2, Section 1.3.12; *see also* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 25.

[121] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 24.

Section Thirteen: What if services are denied, delayed, reduced or terminated? [122]

Filing an AHCA complaint

Enrollees who are having trouble accessing services or who are encountering other problems with their LTC Plan can file an official complaint with AHCA. These complaints are reviewed and responded to by trained staff members. In addition, AHCA identifies issues that may indicate systemic problems. While some issues are not amenable to resolution through the complaint portal and may ultimately require a fair hearing, this informal complaint process is not time intensive and may result in a quick resolution.

- A complaint may be filed either online[123] or by speaking with a Medicaid representative by calling toll free 1-877-254-1055.
- AHCA's online portal gives those filing a complaint the option to remain anonymous. However, if there is an issue that needs to be resolved, the person filing the complaint should be prepared to provide their name and an email address or phone number and provide documentation facilitating communication with AHCA staff, e.g., appointment of representation form, HIPAA release.

Grievances, Appeals, and Fair Hearings

What is the difference between a grievance and an appeal?

Each Plan is required to have a grievance and appeal process that complies with the federal Medicaid managed care regulations.[124] The major difference between a grievance and an appeal is that an appeal should be filed when there is an "adverse benefit determination (ABD)," while a grievance would be filed if the enrollee is unhappy with the plan. For example, an enrollee could file a grievance if he or she was treated rudely.[125]

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[122] Grievance, appeals, and fair hearings are the same for LTC as for the state's managed medical assistance (MMA) plans, https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 83-91, Section VII.

[123] https://ahca.myflorida.com/Medicaid/complaints/. *See also* How to File an AHCA complaint.

[124] 42 C.F.R. §§438.228; 438.56(d)(5); 59G-8.600(3)(b).

[125] 42 CFR § 438.400(b); Fla. Admin. Code 59G-1.100(2)(b) (definition of "grievance")

Filing and resolving a grievance or appeal with the Plan

Grievances and appeals can be filed orally or in writing; however, an oral request for an appeal must be followed with a signed appeal within 10 days (unless the request is for an expedited appeal.)[126] The best practice is to file a written request with the Plan. The enrollee handbook must provide the necessary instructions and information for both grievances and appeals.[127] In addition, any notice of adverse benefit determination should include instructions on how, where, and when to file an appeal. (see discussion below).

The Plan must provide written notice acknowledging the receipt of the grievance or appeal within five business days.[128]

Expedited appeal

Enrollees have the right to an expedited appeal if the standard resolution "could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function." [129]

What are the time standards for filing and resolving grievances and appeals and what notice is required?

Filing and resolution timeframes both for LTC and MMA plans are as follows:

- Grievance – can be filed at any time and must be decided within 90 days.[130]
- Standard appeals - filed orally or in writing within 60 days from the date of the adverse benefit determination notice and must be resolved within 30 days.[131]

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[126] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 84; *see also* 42 C.F.R. § 438.406(b)(3).

[127] 42 C.F.R. § 438.406.

[128] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 84-85. *See also*, 42 C.F.R. § 438.406 (b)(1).

[129] 42 C.F.R. § 438.410; https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 88-89.

[130] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 84.

[131] *Id.* at 86-89.

- Expedited appeals - must be resolved within 48 hours after the managed care plan receives the request whether orally or in writing.[132] The plan shall also provide oral notice to the enrollee by close of business on the day of resolution, and written notice to the enrollee within two (2) calendar days of the disposition.[133]

Note that these time frames can be extended if the enrollee requests an extension. However, if the Plan requests an extension, the Plan must demonstrate to the state the need for additional time and why the extension would be in the enrollee's best interests.

How to ensure the continuation of benefits?

When a beneficiary's previously authorized services are terminated, suspended or reduced, she/he has the right to receive continued coverage of the medical services pending the outcome of an appeal and fair hearing. The importance of the right to "aid pending" for low-income individuals was recognized by the United States Supreme Court in the seminal case of *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970). Accordingly, services must be continued if all of the following occur:

- Appeal involves termination, suspension, or reduction of previously authorized service;
- Services were ordered by authorized provider;
- Period covered by original authorization not expired;
- Enrollee timely files for continued benefits on or before ten calendar days of the plan's notice of adverse benefit determination. [134]

If the beneficiary is provided with continued coverage of the service and ultimately loses the appeal, the cost of the service can be recouped. [135]

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[132] *Id.* at 88-89.

[133] *Id.*

[134] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 86, Section VII.F.1.f.; *see also* Section VII.J.10. at 90; *see also* 42 CFR 438.402(c)(2)(ii).

[135] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 91, Section VII.J.12.; *see also* 42 C.F.R. § 438.420(d).

Advocate Tip:
To ensure that services continue, the appeal must be received by the Plan within 10 calendar days of when the notice of adverse benefit determination was sent. If the appeal is upheld, the fair hearing request must then be filed within 10 calendar days of when the notice of appeal resolution was sent.[136] The request for continuation of services should always be in writing.

Notice of Appeal Resolution
The Plan must send a written notice of the appeal resolution that includes:

- Results of resolution process and completion date; and if the result was not completely in favor of the enrollee, the notice must include:
  - Information about the right to request a fair hearing and how to do so, and
  - Information on the right to continued benefits pending a final determination.[137]

What is an Adverse Benefit Determination (ABD)?

Adverse benefit determinations include:

- Denial, reduction, suspension, termination or delay of a previously authorized service;
- Denial or limited authorization of a requested service determination (e.g., 2 hours of speech therapy/week for 6 months were prescribed and plan approved 1 hour/week for one month);
- Failure to provide service in a timely manner as defined by the State; [138]
- Failure of a Plan to act within required timeframes for resolution of grievance or appeal; and
- Denial in whole or in part of the payment for a service.[139]

[136] 42 CFR 438.420(c).

[137] 42 C.F.R. § 438.408(e); *see also* Core Contract https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 90.

[138] However, neither the AHCA contract with LTC plans nor the 1915(b) waiver request specify a time standard for obtaining a service (appointment).

[139] 42 C.F.R. § 438.400(b); Fla. Admin. Code 59G-1.100(2)(b) (definition of "adverse benefit determination").

In addition, ABDs include the denial of an enrollee's request for an out-of-network service if the enrollee lives in a rural area and there is only one Plan.

Is there a requirement that the Plan appeal process be exhausted before filing a fair hearing?

Enrollees must first exhaust the Plan's appeal process. Thus, a fair hearing can only be requested after notice that the adverse benefit determination has been upheld (at least in part) in the Plan appeal process. [140]

Are there any exceptions to exhaustion requirement?

Yes. If the Plan does not follow the notice and timing requirements in 42 C.F.R. § 438.404(c) (described below), the enrollee is "deemed to have exhausted" the plan appeal process and can request a state fair hearing. [141]

WHAT NOTICE REQUIREMENTS APPLY?

The Supreme Court has long recognized the importance of written notices as part of procedural due process.[142] The federal Medicaid Program regulations which apply to all fair hearings (including for eligibility and non- managed care services) include detailed notice requirements.[143]

Additionally, the 2016 federal Medicaid managed care regulations specifically linked the Plan notice requirements to an "adverse benefit determination" and set forth requirements pertaining to both the content and timing of the notice. [144]

The notice must include the following information:

- The ABD that has been made;
- Reason(s) for the ABD (including the right to copies of all documents relevant to the decision free of charge);

[140] 42 C.F.R. § 438.402; Fla. Admin. Code R. 59G-1.100 (3)(b)1; https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 89, Section VII.J.2.

[141] 42 C.F.R. § 438.402 (c)(1)(A); 42 C.F.R. § 438.408(c)(3); Fla. Admin. Code R. 59G-1.100 (3)(b)2-3.

[142] *Goldberg v. Kelly*, 397 U.S. 254 (1970).

[143] 42 C.F.R. § 431.210 *et seq.*

[144] 42 C.F.R § 438.404.

- Right to request an appeal, including:
  - Information on exhausting one level of appeal
  - Right to request a state fair hearing;
- Process for appeal;
- Circumstances for an expedited appeal and how to request;
- Right to have benefits continue pending resolution of the appeal, including:
  - How to request continued benefits
  - Circumstances under which enrollee may be required to repay the costs of those services.[145]

Additionally, the notice must be accessible to individuals with disabilities or limited English proficiency.[146]

Accordingly, AHCA developed template notices that all managed care plans are required to use, including a template notice of an adverse benefit determination made by LTC Plans.[147] *See* Appendix.

What time standards apply to various notices?

- If the action concerns a termination, suspension, or reduction of a benefit - written notice must be sent 10 days before the date of action.
- If the action concerns a denial of payment - notice must be sent at time of the action-affecting claim.
- If the action concerns a standard service authorization decision that denies or limits services - notice must be sent within 14 days.
- If an expedited service authorization has been requested - notice must be sent within 72 hours.

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[145] https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 85, Section VII.E.1, requires that the plan use the template notice provided by AHCA. *See* Appendix for Template Notice.

[146] 42 C.F.R § 438.10, Fla. Admin. Code R. 59G-1.100(2)(t);

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/plan_comm/PT_18-13_NABDandNPAR-Revised-Templates-Effective-7-24-18_June-21-18.pdf linking to a June 21, 2018 Policy Transmittal requiring that plans use a template notice.

[147] Statewide Medicaid Managed Care (SMMC) Policy Transmittal, 2.24.17, Policy Transmittal: 17:08 at http://ahca.myflorida.com/medicaid/statewide_mc/smmc_plan_comunications_archive.shtml. A copy of the template LTC notice of adverse benefit determination is in the Appendix. *See also* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 85.

- If service authorization is not reached within the time frame specified in 42 C.F.R. § 438.210(d), this constitutes a denial on the date that the timeframe expired. [148]

The following are examples of notices that fail to meet the notice content and time requirements. Thus, exhaustion should be deemed to have occurred and the enrollee can request a fair hearing if, e.g.:

- Enrollee speaks Spanish and notice was only in English; (violates 42 C.F.R. § 438.10(d); *see also* 42 C.F.R. § 438.404 (a));
- Notice did not clearly explain the right to continued benefits; (violates 42 C.F.R. § 438.404(b)(6));
- Notice was not sent within 10 days of a termination, suspension or reduction of previously authorized benefits. (violates 42 C.F.R. § 438.404(c)(1)).

FAIR HEARINGS

Statutory right

Under the federal Medicaid Act, Medicaid beneficiaries have the right to a fair hearing if a claim for medical assistance is denied or not acted on with reasonable promptness. [149]

Exhaustion requirement and exceptions

As discussed above, enrollees must first exhaust the Plan's appeal process. Thus, a fair hearing can only be requested after the Plan issues its notice that the adverse benefit determination has been upheld.[150]

And, as noted above, if the plan does not follow the notice and timing requirements in 42 C.F.R. § 438.404(c), the enrollee is "deemed to have exhausted" the plan appeal process and can request a state fair hearing.[151]

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[148] 42 C.F.R. § 438.404(c).

[149] 42 U.S.C. § 1396a(a)(3).

[150] 42 C.F.R. § 438.402; Fla. Admin. Code R. 59G-1.100 (3)(b)1;

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf 89, Section VII.J.

[151] 42 C.F.R. § 438.402 (c)(1)(i)(A); 42 C.F.R. § 438.408(c)(3); Fla. Admin. Code R. 59G-1.100 (3)(b)2-3.

Advocate Tip:
If counsel is representing an individual at a fair hearing they must submit a Notice of Appearance and an Authorized Representative form.

Filing and Parties

Medicaid appeals related to services for persons enrolled in a managed care plan are directed to AHCA.[152] The Plan is the respondent, and "upon request by AHCA, the Agency may be granted party status by the Hearing Officer."[153]

Hearing rights

Enrollees have the right to:

- Bring witnesses
- Make legal and factual arguments in person and in writing.
- Present evidence, including new evidence not available at time of decision,
- Review medical records and case file free of charge and in advance. [154]

The hearing officer can also obtain, at agency expense, a medical assessment from someone not involved in the original decision. [155]

[152] Fla. Stat. § 409.285(2).

[153] Fla. Admin. Code R. 59G-1.100 (4).

[154] 42 C.F.R. § 438.406(b)(4),(5); *compare* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf at 89-91.

[155] 42 CFR 431.240(b); Fla. Admin. Code R 59G-1.100(17)(n),

Advocate Tip:
If an enrollee is being represented by counsel or someone other than themselves, an authorized representative form must be submitted. This form is issued by the hearing officer and includes the case number. The authorized representative form is issued **after** counsel submits a Notice of Appearance.

Requesting the case file

The federal regulations and state rules both acknowledge the right of the enrollee to receive, free of charge and a reasonable time before the hearing, a complete copy of the enrollee's case file.[156] 42 CFR 431.242; 59G-1.100(12), F.A.C.
This should include the member notes or case notes, which are records of actions by Plan staff (including the Medical Director) related to the enrollee's care or interactions with the enrollee and providers. The enrollee is also entitled to copies of documents or records relevant to the Plan's adverse benefit determination.

Advocate Tip:
Request a copy of the case file and other relevant documents, in writing when filing the appeal and the fair hearing request. If the Plan fails to respond, file an AHCA complaint or contact the Plan's counsel directly. In the case of a fair hearing, if attempts to resolve with Plan counsel are unsuccessful, a motion to compel can be filed.

Discovery and subpoenas

Florida is one of the only states providing discovery in the fair hearing process, including for hearings related to managed care. AHCA's managed care fair hearing rule provides that the Florida Rules of Civil Procedure apply and the Hearing Office may issue orders to "effect the purposes of discovery and to prevent delay." [157]

[156] 42 CFR 431.242; Fla. Admin. Code R 59G-1.100(12),
[157] Fla. Admin. Code R. 59G-1.100(13).

Relief

The hearing officer's Final Order should be rendered within 90 days of the requires for fair hearing, unless the time period is waived by the enrollee or extended by the hearing officer.[158]

Enrollees can also request corrective action retroactive to the date of the error, including payments made by the enrollee to cover services that were improperly terminated. [159]

Advocate Tip:
In addition to requesting the enrollee's case file, helpful discovery can include: 1) Requests for production of documents 2) Interrogatories 3) Requests for Admissions 4) Depositions

[158] 59G-1.100(18), F.A.C.

[159] 42 C.F.R. § 431.246; Rule 59G-1.100(18)(f). *See also*, *See Kurnik v. Department of Health and Rehabilitative Services*, 661 So. 2d 914 (Fla. Dist. Ct. App. 1995) *French v. Dep't of Children & Families*, 920 So. 2d 671 (Fla. 1st DCA 2006).

[160] https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915(b)_LTC_Waiver_Renewal_2021.pdf at 47-48.

Section Fourteen: other advocate/consumer resources

As part of the LTC Waiver, Florida has established the Independent Consumer Safety Program (ICSP). The ICSP coordinates efforts between the Florida Department of Elder Affairs, the Statewide Long-term Care Ombudsman Program (LTCOP), local ADRCs and AHCA.

The ICSP uses staff from LTCOP, DOEA and ADRCs to help enrollees understand and resolve service, coverage, and access complaints. [160]

Pursuant to the Contract, Plans are required to have an enrollee advisory committee that meets at least twice a year to consider issues and "obtain periodic feedback" on any identified problems and suggestions for improvement. Plans submit minutes of these advisory committee meetings, along with the plan's response to identified concerns to AHCA.[161]

Advocate Tip:
Obtain copies of the advisory committee materials for the LTC Plans in your region and, depending on the information received, discuss appropriate strategic responses with your local ADRC and ICSP staff.

[161] https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_B_LTC_2022-02-01.pdf at 39, *see also* 42 C.F.R. 438.110(a).

Section Fifteen: Summary of Relevant Authority

The multiple authorities related to Florida's LTC program (and cited in the endnotes) are summarized below. These authorities include federal and state statutes and regulations (rules); contractual provisions between AHCA and the plans, the Waivers Requests and Approval between the state and federal government; and relevant case law, including Settlement Agreements or Orders.

Federal Statutes:

42 U.S.C. § 1396n.

Federal Regulations:

The 2016 federal Medicaid Managed Care regulations at 42 C.F.R. part 438, a significant regulatory overhaul, increased transparency, and modernized Medicaid's managed care programs. Also, for the first time, CMS included specific provision pertaining to LTSS and defined LTSS for the purposes of managed care.[162]

Other relevant federal regulations include 42 C.F.R. § 435.217 (describing individuals who are eligible for home and community –based services), 42 C.F.R. § 440.180 (providing a description of and requirements for HCBS); and 42 C.F.R. § 441.301, *et seq*., (setting forth the requirements for providing HCBS through a waiver, including the requirements for a "person-centered plan and process.")

Florida Statutes:

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes directing the Agency to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: the Managed Medical Assistance program (MMA) and the Long-Term Care Program (which includes the LTC Waiver). Relevant sections of the Florida Statutes include Fla. Stat. 409.978- 409.985.

Florida Administrative Rules:

The state's relevant administrative rules include the Rule pertaining to screening and wait list prioritization and release, Fla. Admin. Code Rule (or F.A.C.) 59G-4.193 and 59G-4.192.

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162 http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care.

Also relevant are the state rules for plan disenrollment F.A.C. 59G-8.600; the AHCA managed care fair hearings rules described at 59G-1.100, and the DCF income eligibility-related rules at F.A.C. 65A-1.710 *et seq*.

AHCA's Core Contract:

The Agency for Health Care Administration's (AHCA) has a Core Contract, which governs all SMMC plans – both MMA and LTC. Relevant subparts include:

- Attachment II: Scope of Service–Core Provisions, February 1, 2022
- Attachment II, Exhibit II-B–Long-term Care (LTC) Program, February 1, 2022

Waiver Applications and Approvals

AHCA's LTC Waiver applications set forth in detail all aspects of how HCBS will be provided.

Department of Elder Affairs:

The DOEA "*Statewide Medicaid Managed Care Long-term Care Program Enrollment Management System Procedures Manual*," provides a detailed description of the process by which individuals are released from the wait list and the eligibility and enrollment process.

Appendix

1) Abbreviations
2) Services
3) Care plan
4) Supplemental assessment form
5) Template Notice
6) Instructions for Filing a Complaint

Appendix One: Abbreviations

CMS Network	Children's Medical Services Network
DCF	Department of Children and Families
DOH	Department of Health
DM	Disease Management
CMS	Centers for Medicare and Medicaid Services
FS	Florida Statutes
FFS	Fee-for-Service
HMO	Health Maintenance Organization
LTC	Long-term Care
MMA	Managed Medical Assistance
MCO	Managed Care Organization
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDHP	Prepaid Dental Health Provider
PIHP	Prepaid Inpatient Health Plan
PMHP	Prepaid Mental Health Program
PSN	Provider Services Network
STC	Special Terms and Condition
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
The Act	Social Security Act
The Agency	Agency for Health Care Administration

Appendix Two: Services

LTC Program Minimum Covered Services	
Adult companion care	Intermittent and skilled nursing
Adult day health care	Medical equipment and supplies
Assisted living	Medication administration
Assistive care services	Medication management
Attendant nursing care	Nursing facility
Behavioral management	Nutritional assessment/ risk reduction
Care coordination/ Case management	Personal care
Caregiver training	Personal emergency response system
Home accessibility adaptation	Respite care
Home-delivered meals	Therapies: occupational, physical, respiratory and speech
Homemaker	Transportation, Non-emergency
Hospice	

Appendix Three: Care Plan

What is Included in the Person-Centered Plan of Care?

- Every enrollee's person-centered plan of care must include:
  - ✓ Enrollee's name and Florida Medicaid identification number
  - ✓ Plan of care effective date
  - ✓ Plan of care review date (at least every 90 days)
  - ✓ The enrollee's personal goals
  - ✓ The enrollee's strengths and preferences
  - ✓ Routine medical services needed, including how much, how often, and who is providing the service(s)
  - ✓ Availability of natural supports to assist in the enrollee's care
  - ✓ Long-term care waiver services, including how much, how often, and who is providing the service(s)
  - ✓ Each service authorization start and end date (if applicable)
  - ✓ A complete list of services and supports to be provided, no matter who is paying
  - ✓ Medication oversight strategies
  - ✓ Current living arrangement and choice of living arrangement
  - ✓ If the enrollee's current living arrangement and choice of living arrangement differ, a goal toward achieving the chosen living arrangement and barriers to be overcome in achieving the goal
  - ✓ Records of enrollees' advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian
  - ✓ If the enrollee resides in an assisted living facility (ALF), services provided by the ALF, including how much and how often the ALF provides those services
  - ✓ Identification of any existing plans of care and service providers and assessment of the adequacy of existing services
  - ✓ Identification of who is responsible for monitoring the plan of care
  - ✓ Case manager's signature
  - ✓ The word-for-word written statement before the enrollee signature field as follows:
    - *"I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended."*, and
  - ✓ Enrollee or enrollee's authorized representative's signature and date

To learn more about the Statewide Medicaid Managed Care Program:

Visit the Agency's SMMC Program website at www.ahca.myflorida.com/SMMC.

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Long Term Care Person-Centered Care Plan

Enrollee Personal Profile					
Medicaid ID #		POC Eff. Date		Enrollee Effective Date	
First Name		Last Name		MI / Date of Birth	
Location		Facility Name		Enrollee Phone #	
Primary Lang.		Adv. Care Planning		Details	

Family & Social History	
Do you have family or friends nearby?	
If yes, how often do you see them?	
What was your profession and/or jobs you worked?	
Do you volunteer or participate in any social groups?	
What is important to the Enrollee?	
Likes & Dislikes (i.e activities, hobbies, foods, etc.)	
What are your special family / cultural traditions?	
Personal Care or Support Preferences	
What do we need to know about the Enrollee?	
Rituals / Routines that are important to the enrollee	
List any communication limitations	
What method of communication do you prefer?	

What are the enrollee's strengths, preferences and self-care capabilities?

Member modification of HCBS setting:	
Were there any modifications made to the member's HCBS setting since the member's last assessment?	*If yes, detail:*
Provide the specific assessed need for the modification of HCBS setting?	
Does the member's current living arrangement differ from their desired living arrangement?	*If yes, detail:*
What is the member's goal in achieving the desired living environment?	
What are the barriers to the member's choice of living environment?	

List the people chosen (if any) by the enrollee to participate in their Plan of Care development & reviews:

Name	Relationship and Contact Phone Number

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Long Term Care Person-Centered Care Plan

Frequency and Details

Enrollee Name:		Medicaid ID#	

Caregiver/Informal Support Supplemental Assessment

Who does the enrollee live with?			Other:
Can the enrollee be safely left alone?		If yes, what amount of time can the enrollee be left alone?	Notes:
Are there Caregiver/Informal support available to assist with the enrollee's needs and care?		Notes:	

**Caregiver/Informal Support includes supports that are provided to the enrollee. This can include the enrollee's spouse, family members, neighbors, friends, significant others and church or community volunteer organizations that are willing to support enrollee as part of their Person Centererd Plan.

Supplemental Assessment: List of Caregiver/Informal Support

Name of Individual/Organization:

1)

Relationship:

If Other:

Role & Support Provided			
Services	Frequency, Hours and Details	Services	Frequency, Hours and Details
☐ Bathing		☐ Heavy Chores	
☐ Dressing		☐ Light Housekeeping	
☐ Eating		☐ Using Telephone	
☐ Using Bathroom		☐ Managing Money	
☐ Transferring		☐ Preparing Meals	
☐ Mobility		☐ Shopping	
☐ Respite		☐ Managing Meds	
☐ Companion		☐ Transportation	
☐ Other			Details
Stress level			
Limitations			
Willingness to Assist			
Addtl. Responsibilities			

Name of Individual/Organization:

2)

Relationship:

If Other:

Role & Support Provided			
Services	Frequency, Hours and Details	Services	Frequency, Hours and Details
☐ Bathing		☐ Heavy Chores	
☐ Dressing		☐ Light Housekeeping	
☐ Eating		☐ Using Telephone	
☐ Using Bathroom		☐ Managing Money	
☐ Transferring		☐ Preparing Meals	
☐ Mobility		☐ Shopping	
☐ Respite		☐ Managing Meds	
☐ Companion		☐ Transportation	
☐ Other			Details
Stress level			
Limitations			
Willingness to Assist			
Addtl. Responsibilities			

Additional Narrative/Notes	

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Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	

Community Integration: Personal Goal Planning

A goal should address issues that are identified in the care plan to ensure enrollee is integrated into the community. A goal should be built on strengths and includes steps that the enrollee will take to achieve the goal. Goals are reviewed at each visit to include progress of the goal, potential barriers to progress, any changes needed and if the goal has been met. If enrollee refuses to create a goal the reason must be documented.

	OBJECTIVE		DATE DEVELOPED	
	GOAL		GOAL STATUS	
	BARRIER		TIMEFRAME	
	INTERVENTION			
GOAL 2	OBJECTIVE		DATE DEVELOPED	
	GOAL		GOAL STATUS	
	BARRIER		TIMEFRAME	
	INTERVENTION			
	OBJECTIVE		DATE DEVELOPED	
	GOAL		GOAL STATUS	
	BARRIER		TIMEFRAME	
	INTERVENTION			
GOAL 4	OBJECTIVE		DATE DEVELOPED	
	GOAL		GOAL STATUS	
	BARRIER		TIMEFRAME	
	INTERVENTION			
	OBJECTIVE		DATE DEVELOPED	
	GOAL		GOAL STATUS	
	BARRIER		TIMEFRAME	
	INTERVENTION			

Self Management Plan

The enrollee's role in managing the physical and social affects and lifestyle changes associated with their chronic condition or a functional limitation.

How are you managing your lifestyle changes due to your current condition?	

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Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	

LTC Service Plan Details

Service or Item Type	Service or Item Details	Timeframe (m/d/yy)		Amount	Frequency	Provider	Goal
Case Management		Start Date				Sunshine Health	
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
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		End Date					
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		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					

sunshine health

Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	

LTC Service Plan Details

Service or Item Type	Service or Item Details	Timeframe (m/d/yy)		Amount	Frequency	Provider	Goal
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
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		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					

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Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	

Other Existing Care Plans, Services and Service Providers *(i.e. PCP, Medicare, Skilled Nursing Care, Specialty Care, Inpatient Admission, Routine Medical, etc.)*

Service Type	Service Detail, Amount and Frequency	Timeframe (m/d/yy)		Payer Source	Provider
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			
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		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			

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Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	

Behavioral Health - CBH or Non-CBH - Cenpatico Behavioral Health

Service Type	Service Details (If Applicable)	Timeframe (m/d/yy)		Amnt / Freq	Provider
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			

Medication Oversight Strategies (To be reviewed every 90 days)

Medication Management		Please explain enrollee's medication strategy in the description below, even if no barrier was identified.	Recommended Strategies or Intervention	
Description/Details				

Backup/Contingency Plan - If the service provider does not show the back-up plan will be as follows:

Back-up Plan	Full Name		Contact number	
❒ Contact SHP LTC plan	Sunshine Health Plan		1-877-211-1999	
❒ Contact the current provider directly	Contact Servicing Provider		Contact Servicing Provider	
❒ Contact designated responsible party:	1		1	
❒Caregiver, ❒Family, ❒Friend to provide care,	2		2	
❒Other (specify:_____)	3		3	

I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended.

Reason for Plan Of Care Review (at least every 90 days)	Care Manager Signature	Date Signed
Individual and/or Entity Responsible for monitoring the Plan of Care	**Enrollee or Enrollee's Authorized Representative**	**Date Signed**

☐ Signed ☐ Unable to Sign ☐ Refused to Sign ☐ Mailed to POA

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Long Term Care Person-Centered Care Plan

Enrollee Care Plan Summary

Enrollee Name		Date of Birth		Medicaid ID#	

Below is a summary of your plan of care that includes your service providers and the services you are receiving. Your case manager has identified services that meet your needs to provide you with appropriate care services.

HCBS/Covered Services	Provider	Start Date	End Date	Amount and Frequency
Case Management	Sunshine Health			

I (enrollee or enrollee authorized rep.) agreed to each individual provider choice for each service above and each service authorization ? Yes ☐ No ☐

I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended.

Reason for Plan Of Care Review (at least every 90 days)	Care Manager Signature	Date Signed

Enrollee or Enrollee's Authorized Representative	Date Signed

☐ Signed ☐ Unable to Sign ☐ Refused to Sign ☐ Mailed to POA

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Appendix Four: Supplemental Assessment Form

Caregiver Assessment

**Please complete the Caregiver Assessment with the member's natural support who are providing care to the member. This excludes paid caregivers. Assessor should conduct one assessment per caregiver.*

Caregiver Demographics

Caregiver Full Name:				
Caregiver Sex:	☐ Male ☐ Female		Caregiver Date of Birth:	
Caregiver Relationship to individual:	☐ Wife ☐ Son / In-law	☐ Husband ☐ Daughter / In-law	☐ Partner ☐ Other relative	☐ Parent ☐ Other Non-relative
Caregiver Address:				
City:			State:	Zip:
Caregiver Primary Phone Number:			Alternative Phone Number:	
Do you currently have anyone to assist you with providing care?			☐ Yes ☐ No	

Caregiver Questionnaire

Do you work outside the home?	☐ Yes ☐ No	If Yes:	Schedule:
Do go to school outside the home?	☐ Yes ☐ No	If Yes:	Schedule:
Do you have other responsibilities outside the home?	☐ Yes ☐ No	If Yes:	Please describe other responsibilities: Schedule:
Do you currently provide care for this client?		☐ Yes ☐ No	
If Yes, describe the care you are providing and the number of hours for each service provided:			
How many hours per week do you currently spend providing care for the client?			
How long have you been providing care for this client?	☐ Less than 6 months ☐ 1 to 2 years	☐ 6 to 12 months ☐ 2 or more years	☐ NA
Do you need training or assistance in performing caregiving tasks?		☐ Yes ☐ No	
In your opinion, how long can the client be left alone safely?			
Do you experience mental or emotional strain as a result of your responsibility to provide care for the client?		☐ Yes ☐ No	
If Yes, please describe the emotion strain you experience:			

Considering other aspects of your life, please rate the level of difficulty in your:

Relationship with individual:	☐ No Difficulty	☐ Little Difficulty	☐ Some Difficulty	☐ Moderate Difficulty	☐ A lot Difficulty
Relationship with family:	☐ No Difficulty	☐ Little Difficulty	☐ Some Difficulty	☐ Moderate Difficulty	☐ A lot Difficulty
Relationships with friends:	☐ No Difficulty	☐ Little Difficulty	☐ Some Difficulty	☐ Moderate Difficulty	☐ A lot Difficulty
Physical Health	☐ No	☐ Little	☐ Some	☐ Moderate	☐ A lot

Member Name: _____ Member ID Number: _____

Anthem/AGP revised 12/16

	Difficulty	Difficulty	Difficulty	Difficulty	Difficulty
Finances:	☐ No Difficulty	☐ Little Difficulty	☐ Some Difficulty	☐ Moderate Difficulty	☐ A lot Difficulty
Functional Abilities:	☐ No Difficulty	☐ Little Difficulty	☐ Some Difficulty	☐ Moderate Difficulty	☐ A lot Difficulty
Employment:	☐ No Difficulty	☐ Little Difficulty	☐ Some Difficulty	☐ Moderate Difficulty	☐ A lot Difficulty
Time for yourself to do the things you enjoy:	☐ No Difficulty	☐ Little Difficulty	☐ Some Difficulty	☐ Moderate Difficulty	☐ A lot Difficulty
Other responsibilities such as caring for children / other family members, going to school, religious or social activities, etc.:	☐ No Difficulty	☐ Little Difficulty	☐ Some Difficulty	☐ Moderate Difficulty	☐ A lot Difficulty
Are you willing to provide or continue to provide care or services to the client?	☐ Willing to provide More Care	☐ Willing to provide Same Care	☐ Willing to provide Less Care	☐ Unable to provide any care	
How confident are you that you will have the ability to provide or continue to provide care?		☐ Very confident	☐ Somewhat confident	☐ Not very confident	
If not confident, what is the main reason you may be unable to continue to provide care?					
How many hours per week do you think you could reasonable provide going forward?					
Assessor Information					
Is the caregiver in crisis?	☐ Yes ☐ No	If yes, check all that apply:	☐ Financial	☐ Emotional	☐ Physical
Assessor Name:			Date of Caregiver Assessment:		

Appendix Five: Template Notice

PLAN ID: XXXXXXXXXXXXXXXXXXX

<<ENROLLEE>> and/or
<<LEGAL REPRESENTATIVE>>
<<STREET ADDRESS>>
<<CITY, STATE ZIP>>

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear <<ENROLLEE/LEGAL REPRESENTATIVE>>:

<<LTC PLAN>> has reviewed your request for <<SERVICE and AMOUNT>>, which we received on <<DATE>>. After our review, this service has been:

<<PARTIALLY DENIED, DENIED, TERMINATED, SUSPENDED, REDUCED>> as of <<EFFECTIVE DATE OF ADVERSE BENEFIT DETERMINATION>>

We made our decision because:
(Check all boxes that apply)

☐ We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: *(See Rule)*

☐ Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

☐ Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

and one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

☐ The requested **service is not a covered benefit**.

☐ **Other authority** <<explain and cite authority>>

The facts that we used to make our decision are: <<explain>>

SAMPLE This determination of the Medical Director has been made based on medical necessity (as defined by Florida law – specifically see checked box above) and reflects the application of the Plan's approved review criteria and guidelines.
Clinical rationale: for clinician to write – see example for detail below – it would be different for each type of clinician
Example from eQHealth

Clinical Rationale for Decision: The patient is a _____old with a history of gastroesophageal reflux disease and apnea. The patient is on an apnea monitor. Over the past month, the patient had four reported incidences on the monitor. No skilled interventions were required for these reported events. The patient is on oral _____ every 4 hours and requires positioning after meals. The patient is on two scheduled medications and as needed nebulizer treatments. The patient is currently attending during the day. The request is for skilled nursing for 12 hours per day 7 days per week. The patient lives with his _____and _____. The clinical information provided does not support the medical necessity of the requested services. The patient does not have any ongoing skilled interventions which would support skilled nursing. Additionally, the patient does not require nighttime monitoring by a skilled nurse.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge.

You may request these documents by contacting: <<Plan supplied contact information>>

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from <<LTC PLAN>>. When you ask for a plan appeal, <<MANAGED CARE PLAN>> has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 60 days* of the date of this letter. (If you wish to continue your services until a final decision is made on your appeal, we must receive your request sooner. See the "How to Ask for your Services to Continue" section below for details.) Here is where to call or send your request:

<<MCO>>
<<MAILING ADDRESS>>
<<PHONE>>
<<FAX>>
<<EMAIL>>

Your written request for a plan appeal must include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where we can reach you or your legal representative

You may also include the following information if you have it:

- Why you think we should change the decision
- Any medical information to support the request
- Who you would like to help with your plan appeal

Within five days of getting your plan appeal request, we will tell you in writing that we got your plan appeal request unless you ask for an expedited (fast) plan appeal. We will give you an answer to your plan appeal within 30 days of you asking for a plan appeal.

How to Ask for an Expedited (Fast) Plan Appeal if Your Health is At Risk:

You can ask for an "expedited plan appeal" if you think that waiting 30 days for a plan appeal decision resolution could put your life, health, or your ability to attain, maintain, or regain maximum function in danger. You can call or write us (see above), but you need to make sure that you ask us to *expedite* the plan appeal. We may not agree that your plan appeal needs to be expedited, but you will be told of this decision. We will still process your plan appeal under normal time frames. If we do need to expedite your plan appeal, you will get our plan appeal resolution within 48 hours after we receive your plan appeal request. This is true whether you asked for the plan appeal by phone or in writing.

How to Ask for your Services to Continue:

If you are now getting the service that is scheduled to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made in a plan appeal and, if requested, fair hearing. If your services are continued, there will be no change in your services until a final decision is made in your plan appeal and, if requested, fair hearing.

If your services are continued and our decision is upheld in a plan appeal or fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during the plan appeal, you MUST file your plan appeal AND ask to continue your services within this time frame:

File a request for your services to continue with <<LTC PLAN>> no later than 10 days after this letter was mailed OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, whichever is later. You can ask for a plan appeal by phone. If you do this, you must then **also** make a request in writing. **Be sure to tell us if you want your services to continue.**

To have your services continue during the fair hearing, you MUST file your fair hearing request AND ask for continued services within this time frame*:*

If you were receiving services during your plan appeal, you can file the request for your services to continue with the Agency for Health Care Administration (Agency) **no later than 10 days** from the date on your notice of plan appeal resolution OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, **whichever is later**.

What to Do if You Disagree with the Plan Appeal Decision

You will receive the result of the plan appeal process in a notice of plan appeal resolution (notice) that outlines the outcome of the plan appeal. If you still do not agree with our decision, or if you do not receive your notice on time, you can ask for a fair hearing.

How to Ask for a Fair Hearing:

When you ask for a Medicaid fair hearing, a hearing officer who works for the state reviews the decision that was made. You may ask for a fair hearing any time up to 120 days after you get our notice of plan appeal resolution. **You must finish your plan appeal process first.**

You may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

(877) 254-1055 *(toll-free)*
239-338-2642 *(fax)*
MedicaidHearingUnit@ahca.myflorida.com

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request.

If you have questions, call us at <<PHONE>> or <<TTY NUMBER>>. For more information on your rights, review the Grievance and Appeal section in your Member Handbook. It can be found online at: <<WEB ADDRESS>>.

Notice of Nondiscrimination

<< INSERT NONDISCRIMINATION LANGUAGE>>

Sincerely,

<<NAME>>

<<Medical Director or title of other professional who made the adverse benefit determination in accordance with Attachment II, Section VII.G.4 of the SMMC contract>>

Appendix Six: Instructions for Filing a Complaint

How to File a Complaint

Enrollees who are having trouble accessing services or who are encountering other problems with their LTC Plan can file an official complaint with AHCA. For example, enrollees such as Alene, dealing with gaps in their services can file a complaint.

These complaints are reviewed and responded to by trained staff members. In addition, AHCA identifies issues that may indicate systemic problems. While some issues are not amenable to resolution through the complaint portal and may ultimately require a fair hearing, this informal complaint process is not time intensive and may result in a quick resolution.

Below please find step by step instructions on how to file a complaint. It is highly advised to do so in writing and save a copy for yourself.

AHCA's online portal gives those filing a complaint the option to remain anonymous. However, if there is an issue that needs to be resolved, the person filing the complaint should be prepared to provide their name and an email address or phone number and provide documentation facilitating communication with AHCA staff, e.g., appointment of representation form, HIPAA release. There is an AHCA homepage for Florida Medicaid Complaints where you can submit a complaint or check the status of your complaint.

Step 1

- Name
- Whether you are an "Authorized/Legal Representative, Billing Agent, Family/Friend, Government/Authorized Agency/Community Partner, Health/Dental Plan, Provider, or Recipient"
- Your Member #, SSN, or Medicaid ID Card #

Step 2

- Your phone number

- Address
- Email address
- Preferred Communication method and language

Step 3 - at this time you will be given a **Complaint #** and an **Issue #**, keep these for your records

- Whether the affected person is a "Recipient, Provider, or General Population"
- You may be asked to "add person" to the file if it is not the "Recipient"
- The county where the affected person lives
- Whether the issue is regarding "Health/Dental Plan or Medicaid Fee-for-Service"
- Whether the program is "Long Term Care (LTC), Managed Medical Assistance (MMA), or Statewide Dental"
- The name of the Plan

At this time, there will be a series of drop downs that must be completed (Appendix 2 - Detailed Complaint Questionnaire Step 3)

- Which of the following statements best describes the situation?
- What kind of service(s) do you need?
- Did you speak to the plan/Medicaid Helpline about your issue? (yes/no)
- Select one of the following reasons: (for your complaint)
- Do you have any additional information to add prior to submitting your issue to the Agency?
    - Here you should add the language "*See attached documents explaining complaint* (and authorization if relevant)"
    - Below this question there will be option to attach documents and this is where you should add your formal complaint (see Appendix 1 - AHCA Complaint via Portal) (and authorization if relevant)"

After you have completed these steps, you will be given a preview of your entire complaint that says "You're Almost Done!" (see Appendix 3 - Redacted Complaint Preview). **Make a screenshot or copy down the information on this preview for your records.** Then click "Finish" to submit your complaint.