



FLORIDA HEALTH
JUSTICE PROJECT

Advocate's Guide

Florida Medicaid Program

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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 the National Health Law Program whose generous support made this updated edition of the *Florida Advocates Guide to Medicaid* possible.

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SECTION ONE: INTRODUCTION

Medicaid is a complex and frequently changing federal-state insurance program that covers medical expenses for eligible beneficiaries. Each state implements its own Medicaid plan in compliance with the federal Medicaid statute and regulations. While the federal statute and regulations prescribe the basic rules of the Medicaid program, states have significant flexibility and each state’s Medicaid program is unique.

This *Guide* provides an overview of the authority governing Florida’s Medicaid program and addresses basic questions including:

- who is eligible for Medicaid
- how to apply
- what to do if an application is denied or delayed
- what to do if eligibility is terminated
- what services are covered
- how does managed care work
- what to do if services are denied, delayed, terminated, or reduced¹

HISTORY

When the Medicaid program was passed in 1965, coverage was limited to low-income individuals who qualified for either the “disability-related” coverage (aged, blind, or disabled) or “family-related” coverage (children, pregnant women, parents).

Half a century later, the Affordable Care Act eliminated this requirement of a “categorical connection.” The overarching goal of the ACA was to establish a path to affordable medical insurance coverage for all Americans (and eligible immigrants). In addition to providing subsidies to lower the cost of coverage for individuals and families with household income between 100% and 400% of the federal poverty level (FPL)^{2,3}, it also required states to expand their Medicaid program to provide coverage for low-income adults under 133% of FPL.⁴

Shortly after passage of the ACA, Florida and other states sued the federal government alleging, *inter alia*, that this “Medicaid expansion” was unconstitutional. In *National Federation of Independent Business*

¹ This document is intended to provide guidance on basic questions related to applications, eligibility, services, managed care, and appeals. It does not address multiple components of the Medicaid program including, e.g., Institutional Care Medicaid, Home-and Community-Based Waivers, Medicare Savings Programs.

² 26 U.S.C. § 36B (c)(1)(A).

³ See HHS Federal Poverty Guidelines for 2022, <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>.

⁴ 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

v. Sebelius, the U.S. Supreme Court upheld the ACA’s individual mandate as constitutional. The Court also ruled, however, that requiring states to expand their Medicaid programs to cover low-income adults who did not meet a categorical connection was “overly coercive.”⁵ The Court’s decision meant that each state would decide whether to extend coverage to this group.

As of July 2022, Florida is one of 12 states still refusing federal funding for coverage of the Medicaid expansion population. As a result, millions of low-income uninsured adults in non-expansion states have no path to affordable coverage. They fall into what is referred to as the “coverage gap.”⁶ A chronology of the Florida Legislature’s opposition to Medicaid expansion as well as ballot initiative’s refusal to expand Medicaid is detailed in a report entitled: [Opposition, Inaction and Obstruction: a History of Florida’s Failure to Pass Medicaid Expansion.](#)⁷

In response to the ongoing resistance of Florida and other states to providing low-income adults with coverage, Congress has considered legislation that would “close the coverage gap.”⁸ As of July 2022, the U.S. Senate has not passed this bill.

AUTHORITIES, ADMINISTRATION AND FUNDING

Multiple authorities govern the Medicaid program including: the federal Medicaid statute and regulations, the state Medicaid statute and rules, and sub-regulatory guidance from state and federal agencies.

⁵ *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

⁶ The coverage gap includes parents or caregivers whose incomes above Florida’s eligibility for Medicaid, which is only about 30% of the federal poverty level but below poverty, the minimum income eligibility for tax credits through the ACA marketplace. It also includes nondisabled childless adults, no matter how low their income may be. *See, e.g.*, <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

⁷ Jessica Cianci and Miriam Harmatz, Florida Health Justice Project, Brief on Medicaid Expansion History in Florida, <https://www.floridahealthjustice.org/publications--media/opposition-inaction-and-obstruction-floridas-failure-to-pass-medicaid-expansion>

⁸ In November 2021, the U.S. House of Representatives passed the “Build Back Better” Act, which included a “fix” that would temporarily extend marketplace subsidies to those in the “coverage gap” in the 12 states that have not yet expanded Medicaid. *See* “Build Back Better Act: Health Coverage Provisions Explained,” Georgetown University Health Policy Institute, Center for Children and Families, <https://ccf.georgetown.edu/2021/11/19/build-back-better-act-health-coverage-provisions-explained/>. The “coverage gap fix” has been considered by the Senate in 2022 as part of budget reconciliation, but it has not been approved as of the publication date of this Guide. *See* <https://rollcall.com/2022/07/14/push-for-medicaid-home-health-resumes-in-reconciliation-talks/>

SOURCES OF FEDERAL AND STATE AUTHORITY

Federal Law:

-42 U.S.C. §§ 1396 – 1396w-5

-42 C.F.R. §§ 430 – 456-725

Federal Policy:

-Centers for Medicare and Medicaid Services (CMS)

-“Dear State Medicaid Director” Letters

-Regional Letters from CMS (“Dear State Health Official” letters)

(www.cms.gov, www.medicaid.gov)

State Law:

Florida Statutes §§ 409.901-409.9531

Florida Administrative Code 59G

Florida Administrative Code 65A-1

State Policy:

Florida Dept. of Children and Families Program Policy Manual⁹

Florida Medicaid Service Specific Policies¹⁰

At the federal level, Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (USDHHS). CMS divides the states into ten different regions, with a regional office for each. Florida is in Region IV.¹¹

Among other things, CMS issues both guidance and suggested strategies. CMS provides states with sub-regulatory guidance in the form of “Dear State Health Officials” and “Dear State Medicaid Directors” strategies and suggestions. For example, CMS promulgated both official guidance and strategy suggestions with regard to the Covid-19 public health emergency (PHE).¹²

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

⁹ Florida Department of Children and Families, Program Policy Manual, (Feb. 16, 2022), <https://www.myflfamilies.com/service-programs/access/program-policy-manual.shtml>

¹⁰ https://ahca.myflorida.com/medicaid/review/specific_policy.shtml

¹¹ Centers for Medicare & Medicaid Services, CMS Regional Offices, (Feb. 16, 2022), <https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices>

¹² See, e.g., [Unwinding and Returning to Regular Operations after COVID-19](#). (With regard to the Covid-19 PHE unwind, see resources prepared by FHJP. <https://www.floridahealthjustice.org/public-health-emergency.html>)

One of the most significant aspects of the Medicaid program is the financing structure by which the federal government, pursuant to a formula based on the state's poverty level, guarantees federal "matching funds" for the state's expenditures. In Florida, the guaranteed funding formula means that for every \$1 spent on Medicaid-covered services for eligible enrollees, the federal government provides approximately \$0.61.¹³

Had Florida expanded Medicaid under the ACA, the federal government would have paid 100% of Medicaid-covered services for eligible enrollees for the first three years (2014-17). If/when Florida chooses to extend coverage to those low-income adults eligible for Medicaid under the ACA, the federal matching rate for the cost of covering this population will be no less than 90% as of 2020 and thereafter.^{14 15}

¹³ Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2021 Through September 30, 2022 <https://www.federalregister.gov/documents/2020/11/30/2020-26387/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for>.

¹⁴ 42 U.S.C. § 1396d(y)(1).

¹⁵ In 2021, the United States Congress passed the American Rescue Plan Act (ARPA). Under this legislation, any state which had not yet extended Medicaid eligibility and which newly expands Medicaid will receive a bump of 5% of federal funding for the Medicaid matching rate (FMAP) for all non-expansion populations for the following two years. *See* FHJP, "Medicaid Provisions in American Rescue Plan: Impact on Florida Access and Revenue," <https://www.floridahealthjustice.org/publications--media/medicaid-provisions-in-american-rescue-plan-impact-on-florida-access-and-revenue>. As of publication of this Guide, Florida has not expanded Medicaid to take advantage of these benefits.

SECTION TWO: ELIGIBILITY

ELIGIBILITY OVERVIEW

Under federal law, states *must cover* specified mandatory coverage groups, and states *may cover* additional categories who meet eligibility requirements.

Eligibility requirements include financial (income and resources) as well as technical requirements, *e.g.*, citizenship and residency. Different financial eligibility limits and methodologies apply depending on whether the individual’s categorical connection to Medicaid is disability (also referred to as “SSI-related”) or family-related.¹⁶ Eligible individuals who qualify for coverage under any mandatory or optional category are known as the “categorically needy.”¹⁷

States may also cover individuals who otherwise fit into a Medicaid category but whose income or resources exceed the limit. This coverage group, which Florida has adopted, is referred to as “Medically Needy.”¹⁸

The major groups in Florida’s mandatory and optional coverage categories are set forth below:

MANDATORY COVERAGE GROUPS¹⁹

- Low-income parents & caretakers
- Pregnant women (post-partum coverage for 12 months)²⁰
- Children 0-18
- Children 19-20
- SSI recipients, including Protected Medicaid & “Pickle People”²¹

¹⁶ *See, e.g.*, Florida Department of Children and Families (DCF), Program Policy Manual, (Feb. 16, 2022), <https://www.myflfamilies.com/service-programs/access/program-policy-manual.shtml>.

¹⁷ 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396(e)-(f); 42 C.F.R. § 435.4; 42 C.F.R. Part 435, Subpart B; 42 C.F.R. Part 435, Subpart C; *see* CMS, STATE MEDICAID MANUAL §§ 3300-3493, §§ 3500-3596; Fla. Stat. § 409.903; Fla. Stat. § 409.904.

¹⁸ 42 U.S.C. § 1396a(a)(10)(C); 42 CFR 435.4; 42 CFR Part 435, Subpart D; *see* CMS, STATE MEDICAID MANUAL §§ 3600-3645.6; Fla. Stat. 409.904(2); Fla. Admin. Code R. 65A-1.703(6).

¹⁹ 42 U.S.C. § 1396a(a)(10)(A)(i), Fla. Stat. § 409.903, *see also*, Fla. Admin. Code R. 65A-1.703; Fla. Admin. Code R. 65A-1.710 (Note, Florida administrative rules listing family-related and SSI-related coverage groups includes both mandatory and optional coverage groups.).

²⁰ Fla. Stat. § 409.903(5); Florida submitted a § 1115 application to amend its Medicaid Program which has been pending approval from CMS since September 3, 2021, in order to implement this legislative change. *See* CMS, “Florida Managed Medical Assistance,” <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81311>.

²¹ For a description of Florida’s SSI related coverage groups, *see* SSI RELATED MEDICAID PROGRAMS FACT SHEET, <https://www.myflfamilies.com/service-programs/access/docs/ssifactsheet.pdf> (last updated June 2022); for a description of “Pickle People” *see*, National Health Law Program, “A Quick and Easy Method of

- Medicare-related programs
- Youth to age 26 aging out of foster care²²
- Working disabled²³

OPTIONAL COVERAGE GROUPS²⁴

- Emergency Medicaid for aliens (EMA)²⁵
- Women with breast or cervical cancer
- Medically needy
- Persons under state adoption assistance agreements
- Persons needing institutional care
- Medicaid for Aged and Disabled (MEDS-AD)
- HIV patients needing hospital-level of care²⁶

FAMILY-RELATED MEDICAID ELIGIBILITY

Florida’s Family-Related Medicaid Groups include the following groups²⁷:

- Infants aged 0-1
- Children aged 1-5

Screening for Medicaid Eligibility Under the Pickle Amendment,” (Feb. 16, 2022), <https://healthlaw.org/resource/a-quick-and-easy-method-of-screening-for-medicaid-eligibility-under-the-pickle-amendment-2022-update/>

²² 42 CFR § 435.150(b); Fla. Admin. Code R. 65A-1.703(2)(d).

²³ See e.g., AHCA description of program pursuant to the 2019 Working People with Disabilities legislation. https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/wpwd_FAQ.pdf.

²⁴ Fla. Stat. § 409.904; 42 U.S.C. § 1396a(a)(10)(A)(ii)(VIII); Fla. Admin. Code R. 65A-1.703; Fla. Admin. Code R. 65A-1.710.

²⁵ 42 U.S.C. § 1396b(v); 42 C.F.R. § 435.406(b); 42 C.F.R. § 440.255; Fla. Stat. §§ 409.902(2)(b) and 409.904(4); Fla. Admin. Code R. 65A-1.301(1); Fla. Admin. Code R. 65A-1.702(c); Fla. Admin. Code R. 59G-1.050(4) (Note: Florida lists this coverage group in the section of the statute for optional eligibility, Fla. Stat. § 409.904, but coverage should be mandatory under the federal statute).

²⁶ Fla. Stat. § 409.904(11).

²⁷ See Fla. Stat. § 409.903; Fla. Admin. Code R. 65A-1.703; see also DCF Policy Manual for discussion, <https://www.myflfamilies.com/service-programs/access/program-policy-manual.shtml>; note also that there are different optional coverage groups at https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_13.pdf.

- Children aged 6-18
- Children aged 19-21
- Pregnant Women
- Parents/Caretakers of minor children

The eligibility for each group varies based on the household income. For children, the income limit goes down gradually as the child gets older. For example, (based on 2022 poverty guidelines), in a household of 3, the monthly income limit for an infant under age 1 would be \$4040; for a 1-5 year old child it would be \$2783; and for a child age 6-18 it would be \$2649. Once the child turns 19, the income limit drops to the significantly lower income limit for parents and caretakers, i.e. only \$582 for a household of three (3), or \$ 346/month for a household of one (1).

There is no asset test for family-related Medicaid eligibility.²⁸

ADVOCATE'S TIP

Advocates should bookmark, and/or make a copy of DCF's [Family Related Medicaid Income Limits chart](#). See [video and portal materials](#) for explanation on how to use the chart.

CONTINUOUS ELIGIBILITY FOR CHILDREN AND NEW MOTHERS

Under federal law, state have the option of providing continuous eligibility for children even if the family income exceeds allowable limits over the course of the eligibility period.

Pursuant to this option, Florida covers children under age 5 for 12 months; and children under age 19 for 6 months, “regardless of changes in circumstances.”²⁹

Prior to 2022, postpartum coverage was limited to 60 days. In 2021, the Florida Legislature passed a bill which extended postpartum coverage to a full twelve months after birth.³⁰

²⁸ Fla. Admin. Code R. 65A-1.708(2).

²⁹ Fla. Stat. § 409.904(6).

³⁰ Fla. Stat. § 409.903(5); Florida submitted a § 1115 application to amend its Medicaid Program which has been pending approval from CMS since September 3, 2021, in order to implement this legislative change. *See* CMS, “Florida Managed Medical Assistance,” <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81311>.

MODIFIED ADJUSTED GROSS INCOME (MAGI)

Under the ACA, income eligibility for each Family-Related Medicaid group is based on the Modified Adjusted Gross Income (“MAGI”).³¹ The National Health Law Program has provided a comprehensive guide to understanding MAGI.³²

Generally, MAGI includes the adjusted gross income plus certain exclusions such as any tax-exempt Social Security, interest, and foreign income.³³

MAGI does include:³⁴

- Social Security retirement
- Survivors Benefits
- Social Security Disability Insurance (SSDI)

MAGI does not include:³⁵

- Supplemental Security Income (SSI)
- Child Support
- Temporary Cash Assistance (TANF)
- Gifts and Loans
- Proceeds from Insurance Claims
- Inheritance
- Tax Credits/Refunds

For the purposes of calculating MAGI for Medicaid, lump sum payments are counted only for the month they are received. In addition, scholarships, awards, and fellowship grants are not included as income unless they are used for living expenses rather than for education.³⁶

³¹ 42 C.F.R. § 435.600 *et. seq.*; see DCF Family-related income eligibility chart specifying the income limits under each category per household size. https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_07.pdf.

³² See <https://healthlaw.org/resource/advocates-guide-to-magi-updated-guide-for-2018/>.

³³ 42 C.F.R. § 435.603(e); 26 U.S.C. § 36B(d)(2)(B); see 26 U.S.C. § 911 (citing exclusions which are added back in for MAGI under 26 U.S.C. § 36B(d)(2)(B)(i)). See also “What to Include as Income,” <https://www.healthcare.gov/income-and-household-information/income>; Fla. Admin. Code R. 65A-1.707.

³⁴ *Id.*

³⁵ *Id.*

³⁶ 42 C.F.R. § 435.603(e).

The income of every individual included in the household is included in MAGI, except for dependents who are not expected to file a tax return.^{37 38}

SSI-RELATED MEDICAID ELIGIBILITY

Florida's SSI-related Medicaid coverage groups include the following:³⁹

- Supplemental Security Income (SSI)
- Medicaid for Aged and Disabled (MEDS-AD)
- Institutional Care Program
- Hospice
- Program of All-Inclusive Care for the Elderly (PACE)
- Modified Project AIDS Care (MPAC) Program
- Home and Community Based Services (HCBS) Waivers
- Working People w/Disabilities⁴⁰
- Breast and Cervical Cancer Treatment (BCC).
- Familial Dysautonomia (FD)
- iBudget

To meet eligibility requirements for SSI Medicaid, individuals must have resources below \$2,000 for an individual and \$3,000 for a couple.⁴¹ There are exceptions for some of the other SSI-related programs.⁴² For example, in order to qualify for the Medicaid for the Aged (MEDS-AD), the individual resource limit is \$5,000.⁴³ Resources are defined as assets that a person owns and has authority or power to convert to cash or make available for her support.⁴⁴

³⁷ 42 C.F.R. § 435.603(d).

³⁸ Florida amended the state administrative rules to conform to the federal regulation in 2018. *See* Fla. Admin. Code R. 65A-1.702, .703, .704, .705, .707, .708, .716.

³⁹ Fla. Admin. Code R. 65A-1.710, *see also* SSI RELATED MEDICAID PROGRAMS FACT SHEET at 6-7, <https://www.myflfamilies.com/service-programs/access/docs/ssifactsheet.pdf>

⁴⁰ Working people with disabilities is listed in the federal Medicaid statute as a “mandatory” coverage group,⁴² 42 U.S.C. 1396d(s); it is also included in the DCF income and resource chart at A-9 and the SSI fact sheet at page 7. It is not listed in Fla. Stat. §§ 409.903 or 409.904 or the Florida administrative rules for SSI coverage groups, Fla. Admin. Code R. 65A-1.710.

⁴¹ Fla. Admin. Code R. 65A-1.716(5)(a).

⁴² Fla. Admin. Code R. 65A-1.712.

⁴³ Fla. Admin. Code R. 65A-1.712(1)(a); SSI-Related Programs - Financial Eligibility Standards: April 2022, https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf

⁴⁴ 20 C.F.R. § 416.1201(a).

Other SSI-related coverage groups include those who are enrolled in a Medicare Savings Program also called “MSPs.” These programs include QMB, SLMB and QI-1. Depending on the program, eligible individuals receive help with premiums, deductibles, co-insurance, copayments and prescription drugs coverage costs.⁴⁵

Not all resources are counted towards the limit. For example, the principal place of residence, personal effects, household goods, necessary motor vehicles and limited cash value of life insurances are excluded.⁴⁶

All assets are counted towards the limit unless they are specifically excluded. This includes, for example, bank accounts, investments, and the value of real property, cars, boats, life insurance,⁴⁷ and trust funds.⁴⁸ If an individual can prove that something, which ordinarily is counted, is unavailable, it should not be counted.⁴⁹

CITIZENSHIP REQUIREMENTS

To be eligible for Medicaid coverage, an individual must be a U.S. citizen or a “qualified alien.”⁵⁰ With specified exceptions, qualified aliens are prohibited from receiving Medicaid for the first five years after receipt of their qualifying immigration status.⁵¹ There is no coverage for unqualified immigrants except through Emergency Medical Assistance to Aliens (EMA).⁵²

Qualified aliens not subject to the five-year wait include: refugees; asylees; individuals who are veterans or on active-duty military; spouses and children of veterans or active military personnel; American Indians born in Canada; Cuban or Haitian entrants; Amerasian immigrants; trafficking victims; and lawful permanent residents admitted before August 22, 1996 and residing continually in

⁴⁵ <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs>.

⁴⁶ 42 U.S.C. § 1382b(a).

⁴⁷ “Consider the resource value of a life insurance policy to be its cash surrender value (CSV), not its face value (FV).” SSA, POMS, SI 01130.300 C.1 (November 14, 2013).

⁴⁸ “If an individual (claimant, recipient, or deemor) has legal authority to revoke or terminate the trust and then use the funds to meet his food or shelter needs, or if the individual can direct the use of the trust principal for his or her support and maintenance under the terms of the trust, the trust principal is a resource for SSI purposes. Additionally, if the individual can sell his or her beneficial interest in the trust, that interest is a resource.” SSA, POMS, SI 01120.200 D.1.a. (Dec. 11, 2013); this *Guide* is not addressing other resource related provision including, e.g., special needs trusts.

⁴⁹ 20 C.F.R. § 416.1201(a)(1).

⁵⁰ 8 U.S.C. § 1641(b); Fla. Stat. § 409.902(2); DCF Policy Manual §§ 1430, 1440.

⁵¹ 8 U.S.C. § 1613(a); 42 C.F.R. § 435.4062(a)(2).

⁵² 42 U.S.C. § 1396b(v)(2)-(3); 42 C.F.R. § 435.406(b); 42 C.F.R. § 440.255; Fla. Stat. § 409.902(2); Fla. Admin. Code R. 59G-1.050(4).

the U.S. since admission.⁵³ Additionally, in 2016, Florida eliminated the five-year bar through the Immigrant Children’s Health Improvement Act (ICHIA) option for children for Medicaid and CHIP (Florida KidCare).⁵⁴

Qualified aliens subject to the five-year wait period include: adult lawful permanent residents admitted after August 22, 1996 (ineligible from the date of entry or obtaining qualified status, whichever is later); parolees; conditional entrants; and battered aliens.⁵⁵

STATE RESIDENCE

Medicaid eligibility is dependent on state residency.⁵⁶ Individuals are residents of Florida if they reside in the state with the intent to remain. Residency does not depend on the duration of the stay, and individuals are not required to have a permanent or fixed address to establish state residence. Generally, however, the requirement will not be satisfied if the stay is for a temporary purpose or there is intent to return to another state.⁵⁷

Those individuals living in the State for employment purposes without the intent to remain can still meet the residency requirements if: 1) the individual or caretaker relative does not receive assistance from another state; and 2) the individual or caretaker relative came to the state with a job or is seeking employment.⁵⁸

OTHER ELIGIBILITY REQUIREMENTS

In addition to being within a mandatory or optional coverage group and meeting financial, citizenship, immigration, and residency requirements, with certain exceptions, applicants must also:

- have a Social Security number or have applied for one⁵⁹

⁵³ 8 U.S.C. § 1613(b); Fla. Stat. § 409.902(2); DCF Policy Manual § 1430, § 1440

⁵⁴ 42 U.S.C. § 1396b(v)(4)(A); Fla. Stat. § 409.811(17); Fla. Stat. § 409.904(6); Children's Health Improvement Act (ICHIA) Conference Committee Amendments.

⁵⁵ 8 U.S.C. § 1613(a); 8 U.S.C. § 1641.

⁵⁶ 42 U.S.C. § 1396a(b)(2); 42 C.F.R. § 435.403; Fla. Admin. Code R. 65A-1.705(1)(b); DCF Policy Manual § 1430.0300; DCF Policy Manual § 1440.0300.

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ Fla. Admin. Code R. 65A-1.302; DCF Policy Manual §§ 1430.0200, 1430.0204; 42 C.F.R. § 435.910. Note: The federal regulation policy allows for an exception based on a “well established religious objection,” 42 C.F.R. § 435.910(h); the state rule allows for “good cause failure to provide SSN.” Fla. Admin. Code R. 65A-1.302(3); however, the DCF program manual does not provide for any exceptions. *See* §§ 1430.0200, 1430.0204.

- provide verification of all health insurance
- assign to the state all rights to payment for health care from any third parties
- cooperate with the local child support enforcement agency in establishing paternity and securing medical and child support for any deprived child for whom the individual is caretaker when assistance is requested for the child⁶⁰
- apply for all other benefits to which they are entitled and not be residing in a penal institution⁶¹

RETROACTIVE MEDICAID (RME)

Under federal Medicaid law, costs incurred during the three months prior to the month of application must be reimbursed if: 1) they are covered under the Florida Medicaid plan; and 2) the beneficiary would have been eligible for Medicaid at the time the expenses are incurred.⁶² This important consumer protection is referred to as “RME.”

In 2018, Florida received approval from the federal government through a § 1115 waiver to waive the RME requirement in the Medicaid statute for non-pregnant adults over 21 and to limit coverage to one month.⁶³ The Florida Legislature has attempted to permanently eliminate RME through a statutory amendment. Although the amendment has not been passed, Florida continues to utilize section 1115 authority to waive the RME protection for non-pregnant adults over 21.⁶⁴

⁶⁰ This requirement only applies to parents; pregnant women and children are not required to cooperate with Child Support Enforcement to be eligible for Medicaid. *See* 42 U.S.C. § 1396d(r)(5); Fla. Admin. Code R. 65A-1.702(6).

⁶¹ Fla. Admin. Code R. 65A-1.702(5).

⁶² 42 U.S. C. § 1396a(a)(34).

⁶³ 42 U.S.C. § 1315(a) (Sec. 1115 of the Social Security Act allows the Secretary of HHS to waive some requirements of the Medicaid Act so that states can test novel approaches to improving medical assistance for low-income people).

⁶⁴https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_MMA_Extension_STCs_1.15.2021.pdf. approving 1115 waiver until June 30, 2030. *See also* State of Florida, Department of Children and Families (2019), Transmittal No. P-19-01 0002 (https://www.floridahealthjustice.org/uploads/1/1/5/5/115598329/2019_11_10_elimination_of_retro_coverage_p19010002.pdf). *See also* SB192 (2019): Medicaid Eligibility, <https://www.flsenate.gov/Session/Bill/2019/192/ByCategory>. *See also* “George’s Story,” illustrating the importance of RME for vulnerable Floridians. *Florida Health Justice Project*, <https://archive.floridahealthstories.org/george>.

SECTION THREE: APPLICATIONS, DETERMINATIONS, AND APPEALS

Individuals who meet the state's requirements for eligibility are entitled Medicaid. With the exception of home and community-based (HCBS) waivers, states may not place limits on enrollment or place applicants on waiting lists. In other words, Medicaid is an "entitlement."⁶⁵

In Florida, the Department of Children and Families determines eligibility.⁶⁶ There is a "no wrong door" policy for applicants,⁶⁷ which means that if someone applies to the wrong agency, e.g., KidCare or the federal healthcare marketplace, they should be directed back to DCF.

APPLYING FOR FAMILY-RELATED MEDICAID

While there is a "no wrong door" policy, and applications can be made in person with a DCF community partner, at a DCF community service center, by paper application through the mail, by fax, online at the DCF ACCESS Florida website, <http://www.myflorida.com/accessflorida>, or online at the Health Insurance Marketplace website, www.healthcare.gov, it is advised to apply through DCF's online ACCESS application.⁶⁸

ADVOCATE'S TIP

If at all possible, applicants are advised to apply online to DCF's Access website at <https://dcf-access.dcf.state.fl.us/access/index.do> and to save their user ID and password.

DCF has 45 days to process the application and issue an eligibility determination.⁶⁹

APPLYING FOR DISABILITY-RELATED MEDICAID

There is also "no wrong door" for Medicaid applications based on disability and someone should be able to apply with both [SSA](#) and DCF.⁷⁰ The DCF is required to process a Medicaid application

⁶⁵ See *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981).

⁶⁶ Fla. Stat. § 409.902(1).

⁶⁷ <https://www.macpac.gov/wp-content/uploads/2018/11/Florida-Summary-Report.pdf>

⁶⁸ Fla. Admin. Code R. 65A-1.205; 42 U.S.C. § 18083; 42 U.S.C. § 1396w-3; *Frequently Asked Questions*, Department of Children and Families, <http://www.myflfamilies.com/service-programs/access-florida/faq> (Scroll down to heading, "How do I apply?").

⁶⁹ 42 C.F.R. § 435.911(a)(1); Fla. Admin. Code R. 65A-1.205(1)(b).

⁷⁰ Fla. Admin. Code R. 65A-1.205, 42 U.S.C. § 18083; 42 U.S.C. § 1396w-3; *Frequently Asked Questions*, Department of Children and Families, <http://www.myflfamilies.com/service-programs/access-florida/faq>.

within 90 days.⁷¹ If the application is denied, there is a right to appeal the denial before an independent DCF hearing officer. The DCF hearing officer is required to issue a decision within 90 days of the request for an appeal.⁷²

Despite the 90-day deadline, applications are often delayed on the basis that DCF needs additional information. Applicants and advocates should note that under case law, DCF has an affirmative duty to assist individuals in applying for Medicaid.⁷³ Additionally, if the determination is improperly delayed or denied and the individual files a successful appeal, the recipient is entitled to full reimbursement for out-of-pocket expenses incurred while attempting to apply.⁷⁴

Individuals who are applying for Medicaid **and** Social Security Disability benefits need to apply through a Social Security Administration office or the SSA website. SSI recipients will automatically be routed to the Division of Disability Determinations (DDS), which reviews applications for Medicaid.⁷⁵ SSDI recipients whose income is too high for Medicaid will need to apply directly to DCF for “Medically Needy” enrollment.⁷⁶

If DDS makes an adverse decision within 90 days (the time standard for Medicaid eligibility decisions based on disability),⁷⁷ the applicant can then begin the appeal process.⁷⁸

Additionally, if the SSA has determined that the applicant is not disabled, the adverse decision will likely preclude the applicant from being found eligible for Medicaid by DCF with limited exceptions.⁷⁹

⁷¹ Fla. Admin. Code R. 65A-1.205(1)(c)(4).

⁷² Fla. Admin. Code R. 65-2.066(5)

⁷³ See *Pond v. Dep't of Health & Rehab. Servs.*, 503 So. 2d 1330, 1331 (Fla. 3d DCA 1987) (where “a caseworker is presented with specific and revealing information regarding the applicant's eligibility for benefits, that caseworker has an affirmative duty under 45 C.F.R. § 206.10(a)(2)(i) to inform that applicant at least orally of the conditions relevant to her eligibility).

⁷⁴ 42 C.F.R. 431.246; see also *Kurnik v. Department of Health and Rehabilitative Services*, 661 So. 2d 914, 917 (Fla. 1st DCA 1995) (holding that the Appellant’s right to apply for Medicaid and have her application processed in timely fashion was “inexplicably and inexcusably delayed” by the agency. The court stated that the appellant's “Kafkaesque experience with that agency was characterized by no information, misinformation, unanswered letters, unreturned phone calls, unfulfilled promises, and classic bureaucratic runaround the sum total of which amounted almost to studied indifference if not purposeful neglect on the part of the agency.”).

⁷⁵ <https://www.floridahealth.gov/programs-and-services/people-with-disabilities/disability-determinations/>

⁷⁶ [Medically Needy Program Information Flyer, https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/2600.pdf](https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/2600.pdf).

⁷⁷ Fla. Admin. Code R. 65A-1.205(1)(c)(4).

⁷⁸ Fla. Admin. Code R. 65A-2.042.

⁷⁹ 42 C.F.R. § 435.541(c)(2)-(4).

REDETERMINATIONS

Medicaid recipients are subject to a periodic review of their eligibility. Redetermination requires re-verification of certain eligibility factors.⁸⁰

Generally, only information that is subject to change, such as income, household composition, and disability, must be re-evaluated. Items that are not usually subject to change, such as citizenship and residence, need not be reevaluated unless a change has been reported.

Under the ACA, this process was changed for Medicaid beneficiaries whose financial eligibility is determined using the MAGI-based income rule to provide that eligibility be renewed once every 12 months and no more frequently than every 12 months.⁸¹

Given the improved databases available post ACA, states are required to perform the renewal based on information that is already available if possible.⁸² Redeterminations of eligibility without requiring additional information from the beneficiary are referred to as “ex parte determinations”.

If the state does not have the information needed to renew eligibility, they should send a pre-populated notice to the individual specifying the information that is needed and giving at least 30 days to provide the necessary information.⁸³ The preferred method for reporting changes is via the individual’s on-line My ACCESS Account.

If the individual fails to provide the information needed for renewal, coverage will end. DCF will send a Notice of Case Action notifying the individual (or assistance group) that coverage will end by a certain date.

If the case is closed but the renewal or requested verification is returned within three months of the closure date, DCF will timely reconsider eligibility without the need for a new application, and Medicaid will be reinstated back to the effective date of closure.⁸⁴

⁸⁰ Fla. Admin. Code R. 65A-1.704(1); 42 CFR § 435.916.

⁸¹ Fla. Admin. Code R. 65A-1.704(1); 42 C.F.R. § 435.916(a)(1).

⁸² Fla. Admin. Code R. 65A-1.704(2); 42 C.F.R. § 435.916(a)(2).

⁸³ 42 C.F.R. § 435.916 (a)(3)(i) requires that states send a “pre-populated renewal form.” As of July 2022, the forms and notices used by DCF can be found [here](#). The notice specifying the missing information can be found in the “[Medicaid Pending Notice](#).”

⁸⁴ Fla. Admin. Code R. 65A-1.704(2)(b)2.; 42 C.F.R. § 435.916(a)(3)(iii).

EX PARTE DETERMINATIONS

Under Medicaid law, AHCA must continue to provide Medicaid to beneficiaries unless/until the individual is found to be ineligible. In other words, DCF must on its own (or “*ex parte*”) determine whether a Medicaid beneficiary who is no longer eligible under one coverage group is eligible under a different coverage group, and coverage must be continued during this process.⁸⁵

For example, DCF must perform an *ex parte* review when:

- An increase in income or assets causes ineligibility under the enrollee’s current coverage category
- An individual’s SSI is cancelled

In 2019, a class action lawsuit was filed against Florida state agencies responsible for administering the state Medicaid program alleging that the agencies improperly terminated Medicaid coverage without first examining the individual’s continued eligibility under *all* Medicaid categories and without providing proper notice of the action (the “*ex parte* review” requirement).⁸⁶ Pursuant to a settlement in 2020, the state implemented comprehensive corrective actions.⁸⁷

NOTICE AND HEARING RIGHTS

Pursuant to the federal Medicaid law and the Due Process clauses of the U.S. Constitution’s Fifth and Fourteenth Amendments, applicants and recipients have a right to both notice and a hearing when a claim for assistance is denied or not acted on with “reasonable promptness.”⁸⁸

Individuals are entitled to notice and an opportunity for a hearing when the state makes an adverse action including decisions which deny, terminate, or modify assistance, or failing to take an action within a reasonable time.⁸⁹

⁸⁵ 42 C.F.R. § 435.930; 42 C.F.R. § 435.1003; Fla. Admin. Code R. 65A-1.702(4); Access 0830.0600; *see also* Department of Children and Families, TRANSMITTAL No: P – 11-06-0007 (June 7, 2011), *Supplemental Security Income Termination Review Process*.

⁸⁶ *Harrell et. al. v. Poppell et. al.*, No. 3:19-CV-00912 (M.D. Fla. Feb. 25, 2020).

⁸⁷ Florida Health Justice Project, *February 2021 Newsletter*, “[Securing Medicaid Eligibility for Tens of Thousands: Update on Harrel et. al.](#),” summarizing corrective actions implemented by the state including: reinstatement of over 32,000 Floridians to Medicaid, extensive staff training, revised agency policies and notices, and investing over half a million dollars in technology to better determine individual’s ongoing Medicaid eligibility. *See also*, [Policies and notices implemented in response to the litigation](#).

⁸⁸ U.S. Const. amends. V and XIV, § 1; 42 U.S.C. § 1396a(a)(3); *Goldberg v. Kelly*, 397 U.S. 254 (1970).

⁸⁹ *Id.*

A timely written notice is also required and must contain the following:⁹⁰

- statement of the intended action
- reasons for the action
- citation to the law supporting the action
- explanation of the right to a hearing
- explanation of the circumstances under which a hearing will be granted in cases of an action based on a change in law
- explanation of the circumstances under which Medicaid is continued if a hearing is requested

Florida provides the right to discovery in administrative hearings as to both eligibility and services determinations.⁹¹

Eligibility disputes, unlike disputes over coverage of services, (*see supra* Section Five on managed care), are conducted at the DCF Office of Appeal Hearings pursuant to Florida Administrative Code Rule 65-2.

One important exception to the right to a hearing is if the only reason for the termination was change in the federal law.⁹² In such a case, no hearing is required.

⁹⁰ 42 C.F.R. § 431.210.

⁹¹ Fla. Admin. Code R. 65A-2.057(6).

⁹² 42. C.F.R. § 431.220(b).

SECTION FOUR: SERVICES

OVERVIEW

In determining if a particular service is covered for adults, it must be either a mandatory service or an optional service that Florida has elected to cover.

As discussed more fully below, for recipients under age 21, services that are either optional or mandatory must be covered if necessary to “correct or ameliorate” a condition or illness.⁹³

The federal statute lists 29 categories of the services that are covered under Medicaid as either optional or mandatory.⁹⁴

Litigation has arisen when there is a difference of opinion between the state Medicaid agency and beneficiaries over whether a specific service or item fits into one of the categories enumerated in §1396d(a).

For example, *Smith v. Benson* addressed the issue of whether medical incontinence supplies including diapers, must be covered for recipients under age 21 when prescribed for an incontinence-based medical condition. The state Medicaid agency argued that diapers and other incontinence supplies did not fit under any of the enumerated categories of coverage in section 1396d(a). The plaintiffs prevailed by establishing that diapers are included within the home health service coverage category.⁹⁵

FLORIDA MEDICAID SERVICES⁹⁶

MANDATORY SERVICES⁹⁷

The federal statute § 1396a(a)(10) requires that certain services in § 1396d(a) must be provided, and Florida has listed these “mandatory” services in the state statute at Fla. Stat. § 409.905:

⁹³ 42 U.S.C. § 1396d(r)(5).

⁹⁴ 42 U.S.C. § 1396d(a).

⁹⁵ See *Smith v. Benson*, 703 F. Supp. 2d 1262 (S.D. Fla.) (Challenged state Medicaid rule that excluded coverage of diapers without an exception for recipients under age 21).

⁹⁶ As discussed in the Guide’s Section on Medicaid managed care, virtually all Florida Medicaid recipients are enrolled in a managed care organization (MCO). Thus, they receive their services through the MCO. The services, both mandatory and optional, which are covered under Florida’s managed care plan contracts are listed in the Scope of Services Contract (Feb. 1, 2022).
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_I_Scope_of_Services_2022-02-01.pdf

⁹⁷ Fla. Stat. § 409.905.

- Physician services
- Laboratory/x-ray
- In-patient, out-patient hospital and nursing facility
- EPSDT
- Family planning services & supplies
- FQHCs and rural health clinic services
- Nursing facility services
- Advanced registered nurse practitioner services
- Home health care

OPTIONAL SERVICES⁹⁸

The optional services Florida has chosen to cover currently include:

- Prescription drugs
- Adult Dental
- Adult preventative health screenings
- Ambulatory Surgical Center Services
- Case Management services
- Birth Center
- Chiropractic services
- Community Mental Health Services
- Dialysis
- DME
- Healthy Start
- Hearing services
- Home and Community-Based Services (“HCBS”) – through waiver only⁹⁹
- Hospice
- ICF/DD
- Optometric
- Physician Assistant
- Podiatry
- State Hospital
- Assistive Care
- Anesthesiologist Assistant
- Intermediate care services
- Visual care

⁹⁸ Fla. Stat. § 409.906.

⁹⁹ Unlike other optional services, which the state *must* cover for all children if medically necessary under EPSDT and for adults if the service meets the state’s definition of “medical necessity”, most HCBS services are not an “entitlement.” Instead, they are only available to individuals enrolled in one of the state’s HCBS waiver programs. *See, e.g., Advocate’s Guide to LTC Program* <https://www.floridahealthjustice.org/guide-to-long-term-care-medicaid-waiver.html>.

GENERAL PRINCIPLES OF MEDICAID SERVICES

After determining if a service can be covered under Medicaid, certain principles apply, including that: the services must be “medically necessary” for the individual beneficiary; that services be “comparable” between recipients; that “cost sharing” be nominal; and that the services be provided with “reasonable promptness.” These governing principles are discussed more fully below.

COST-SHARING

Minimal cost sharing is allowed under federal law and the Florida Legislature has adopted cost sharing for certain services.¹⁰⁰

However, there is currently an exemption disallowing cost sharing for beneficiaries enrolled in a managed care plan. Thus, because most Florida beneficiaries are enrolled in managed care, cost sharing is not generally an issue in Florida.¹⁰¹

PROVIDER PARTICIPATION & BALANCE BILLING

Another major governing principle is that if a provider accepts Medicaid, they must accept Medicaid as payment in full. Except for allowable cost sharing authorized under federal law and the state plan, providers cannot bill patients for services.¹⁰²

COMPARABILITY

Services made available to categorically needy individuals may not be less in amount, duration, or scope than services made available to the medically needy. Additionally, services made available to individuals in the categorically needy or medically needy group must be equal in amount, duration, and scope for all individuals in the group.¹⁰³

Put another way: comparability prohibits the state from providing a different amount, duration, and scope of benefits for categorically eligible people. Thus, there cannot be discrimination between recipients based on their eligibility category, i.e., family Medicaid v. disability Medicaid, or based on

¹⁰⁰ 42 U.S.C. §§ 1396a(a)(14), 1396o, Fla. Stat. § 409.9081; Fla. Admin. Code R. 59G-1.056.

¹⁰¹ Fla. Stat. § 409.9081(3)(f).

¹⁰² 42 C.F.R. § 1396a(a)(25)(C); 42 C.F.R. § 447.15, 447.20; Fla. Admin. Code R. 59G-1.050 (2), (8) (See proposed amendment on June 17, 2022 that could change cite to (2), (9)).

¹⁰³ 42 U.S.C. § 1396a(a)(10)(B)(i); 42 C.F.R. §§ 440.230(c), 440.240(b)(1).

recipients' diagnoses. For example, if the state covers behavioral treatments but then excludes coverage of any behavioral treatments based on diagnosis, that would violate comparability.¹⁰⁴

REASONABLE PROMPTNESS

In contrast to the time standards for determining eligibility (45 days for determination based on family-related, 90 days for determination based on SSI-related Medicaid), Medicaid 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.¹⁰⁵

As discussed below, the Medicaid managed care regulations require access standards, thus providing advocates and beneficiaries with a basis for addressing service delays.

MEDICAL NECESSITY

In determining if a *coverable* service must be provided to an individual beneficiary (including the amount, e.g., physical therapy twice a week), the service must be “medically necessary.” And while specific services must be included in state Medicaid plans, except for services provided for recipients under age 21 pursuant to ESPDT, there is no explicit definition of the minimum level of each service. Nor is there a definition of medical necessity in federal law for adults. Rather, the applicable federal regulation simply provides that the service must be sufficient in “amount, duration, and scope” to achieve its purpose.¹⁰⁶

Individual states have significant flexibility in setting amount, duration, and scope standards. Thus, for example, Florida has limited coverage for adult inpatient hospital stays to 45 days per year. This is a “reasonable” limit because it is sufficient in amount to cover the inpatient hospital needs of most beneficiaries.¹⁰⁷

By contrast, states cannot limit the coverage of services for recipients under 21 if the service is medically necessary for the individual child. For example, if it is medically necessary, up to 365 days/year of hospitalization must be covered for recipients under age 21.

¹⁰⁴ *K.G. ex rel. Garrido v. Dudek*, 981 F. Supp. 2d 1275 (S.D. Fla. 2013), *aff'd in part and modified in part*, 731 F. 3d 1152 (11th Cir. 2013) (Court entered declaratory judgment finding that AHCA’s rule excluding coverage of any behavioral treatments for children with certain diagnoses, including violated Medicaid comparability requirements. Court of Appeals ordered that previously unpublished Declaratory Judgment, including ruling on comparability not addressed in the permanent injunction, be published.).

¹⁰⁵ *Doe 1-3 ex rel. Doe Sr. 1-13 v. Chiles*, 136 F. 3d 709 (11th Cir. 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.).

¹⁰⁶ 42 C.F.R. § 440.230.

¹⁰⁷ 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 Cir. 1980) (holding that Florida’s rule limiting physician visits to 3/month did not violate federal Medicaid law.).

FLORIDA'S DEFINITION OF MEDICAL NECESSITY¹⁰⁸

“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.

EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a comprehensive set of benefits that are mandatory for children and youth under age 21 who are enrolled in Medicaid. EPSDT covers four separate types of screening services and includes immunizations, laboratory tests, and health education. Each screen must be furnished at pre-set intervals and when a problem is suspected.

The treatment component of EPSDT includes any necessary health care, diagnostic services, and other measures described in the Medicaid Act necessary to “correct or ameliorate” physical and mental conditions.¹⁰⁹

MEDICAL SCREENS

Screens, or well-child check-ups, are a basic element of the EPSDT program. As noted above, four separate types of screens are required: medical, vision, hearing, and dental.

The medical screen must include at least the following five components:

1. A comprehensive health and developmental history, including regarding mental health
2. A comprehensive, unclothed physical exam
3. Immunizations

¹⁰⁸ Fla. Admin. Code R. 59G-1.010, *Definitions Policy*, section 2.83 at 7.
https://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf

¹⁰⁹ See Florida Health Justice Project, “The Right to Medically Necessary Treatment for Florida’s Children,” March 30, 2021, <https://www.floridahealthjustice.org/publications--media/the-right-to-medically-necessary-treatment-for-floridas-children>.

4. Laboratory testing when appropriate (at least at 12 and 24 months of age), including lead tests
5. Health education and anticipatory guidance

Medical screens must be provided according to a “periodicity schedule.”¹¹⁰

VISION, HEARING, AND DENTAL SERVICES

EPSDT recipients are also entitled to periodic vision, hearing, and dental examinations, as well as diagnosis and treatment for vision, hearing, and dental problems.

Vision services must include vision screens, diagnosis, and treatment of vision defects, including eyeglasses.

Hearing services must include hearing screens and diagnosis and treatment for defects in hearing, including hearing aids.

Dental services must include dental screens, relief of pain and infections, restoration of teeth, and maintenance of dental health.

Vision, hearing, and dental services must each be provided according to individual periodicity schedules.¹¹¹

INTERPERIODIC, OR “AS NEEDED”, SCREENS

In addition to covering scheduled, periodic check-ups, ESPDT covers visits to a health care provider when needed outside of the periodicity schedule to determine whether a child has a condition that needs further care. These types of screens are called “interperiodic screens.”

Persons outside the health care system (for example, a teacher or parent) can determine the need for an interperiodic screen. Any encounter with a health care professional acting within the scope of practice is an interperiodic screen, even if the provider is not participating in the Medicaid program at the time the screening services are furnished.¹¹²

¹¹⁰ 42 U.S.C. § 1396d (r)(5)(1); AHCA’s website specifies the state’s schedule for health checkups at the following website, which also specifies that Florida follows the Bright Futures/ American Academy of Pediatrics recommendations. <http://ahca.myflorida.com/medicaid/childhealthservices/chc-up/index.shtml>.

¹¹¹42 U.S.C. § 1396d (r)(2)-(4); <https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx>.

¹¹² *K.G. ex rel Garrido v. Dudek*, 839 F. Supp. 2d 1254, 1275 (S.D. Fla. 2013)(In granting preliminary injunction, court rejected Defendant’s claim that plaintiff cannot show a substantial likelihood of success on the merits because he has failed to allege that his autism was discovered through an “EPSDT” screening, noting that “inter-periodic screens include any visit to a physician (including family-initiated visits) to determine if the child has a condition requiring further assessment, diagnosis or treatment.”).

THE “T” IN EPSDT

In addition to screening, vision, dental and hearing services, the Medicaid Act defines the EPSDT benefit to include “necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions.”¹¹³ This includes all mandatory and optional services that the state can cover under Medicaid, regardless of whether such services are covered for adults.¹¹⁴

For example, if a child needs personal care services to ameliorate a behavioral health problem, EPSDT should cover those services to the extent the child needs them – even if the state places a quantitative limit on personal care services or does not cover them at all for adults.¹¹⁵

ADVOCATE’S TIP

Florida’s definition of “medical necessity”, which is the same for adults and children, has been successfully challenged as overly restrictive for children in violation of EPSDT by a number of state District Courts of Appeal,¹¹⁶ and a 2021 class action challenging the state’s “medical necessity” standard as applied to recipients under age 21 is currently being litigated. Medicaid recipients under 21 who have been denied coverage of services prescribed as medically necessary can contact Florida Health Justice project regarding the pending class action.¹¹⁷

¹¹³ 42 U.S.C. § 1396d (r)(5).

¹¹⁴ See *Smith v. Benson* 703 F. Supp 2d 1262 (S.D. Fla. 2010) (finding that state must cover incontinence supplies for children even though they are an optional benefit and not covered for adults. “every Circuit which has examined the scope of the EPSDT program has recognized that states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a)”. *Id.* at 1269.

¹¹⁵ *C.F. v. Dept. of Children and Families*, 934 So. 2d 1 (Fla. 3rd DCA 2006) (Successfully challenged the state’s reduction of personal care services (PCA) for severely disabled child. The Court found that the state was using an overly restrictive definition of PCA and medical necessity in violation of federal Medicaid law.).

¹¹⁶ See, *C.F. v. Department of Children and Families*, 934 So. 2d 1, 7 (Fla. 3d DCA 2005) (in evaluating whether a state agency correctly analyzed a child’s need for Medicaid services under Fla. Admin. Code R. 59G-1.010, the court held that the agency “incorrectly used more restrictive definitions of ‘medical necessity . . . than federal law requires.”); see also *Q.H. v. Sunshine State Health Plan*, 307 So.3d 1, 12 (Fla. 4th DCA 2020) (finding that “under the EPSDT, the state’s assessment of medical need for a child’s treatment ‘cannot be limited to a predefined list of criteria.’”) (citations omitted); *I.B. v. AHCA*, 87 So.3d 6 (Fla. 3d DCA 2012); *E.B. v. AHCA*, 94 So.3d 708 (Fla.4th DCA 2012).

¹¹⁷ See *W.B. v. Marsteller*, 3:21-cv-00771, (M.D. Fla. 2021), https://www.floridahealthjustice.org/uploads/1/1/5/5/115598329/w.b._complaint_filed.pdf. See also, Florida Health Justice Project, “The Right to Medically Necessary Treatment for Florida’s Children,” March 30, 2021, <https://www.floridahealthjustice.org/publications--media/the-right-to-medically-necessary-treatment-for-floridas-children>

INFORMING ELIGIBLE FAMILIES ABOUT EPSDT

States are required by federal law to inform all Medicaid-eligible persons in the state who are under age 21 of the availability of EPSDT and immunizations. States must use a combination of written and oral methods to effectively inform eligible individuals about: (1) the benefits of preventive health care; (2) the services available through EPSDT; (3) that services are without charge, except for premiums for certain families; and (4) that support services, specifically transportation and appointment scheduling assistance, are available on request.

If the child or family has difficulty reading or understanding English, then the information needs to be conveyed in a format that can be understood.

The agency must also “arrange for (directly or through referral to appropriate agencies, organizations or individuals) corrective treatment.”¹¹⁸

¹¹⁸ 42 U.S.C. § 1396a(a)(43)(c); 42 C.F.R. § 441.62.

SECTION FIVE: MANAGED CARE

BACKGROUND

Florida was one of the first states to mandate enrollment in managed care plans. In 2006, the state received approval for a section 1115 Waiver¹¹⁹ that shifted Medicaid beneficiaries out of a fee-for-service delivery model (also referred to as “traditional” or “straight” Medicaid) into a managed care system.

The initial managed care program, which was known as “Medicaid Reform,” was piloted in five counties. After years of negotiations with the Center for Medicaid and Medicare Services (CMS), the State received permission to expand managed care statewide. The shift was completed in 2014, and most Florida Medicaid recipients are now enrolled in a program referred to as the Managed Medical Assistance Program (MMA).

Almost all Florida Medicaid recipients now receive their health care services through their MMA plan. Broadly speaking, the goal of managed care is to ensure better health outcomes with lower costs. Florida’s program is intended to improve the access standards that were available under traditional fee-for-service Medicaid. Additionally, managed care makes it easier to predict costs.

Because MMA plans control access to services for Medicaid beneficiaries, consumer advocates should be aware of the relevant authority governing Florida’s managed care program. For example, when assisting clients who may experience delays in receiving appointments, it is important to know the access standards prescribed in the managed care contract between the plans and AHCA.

There is a significant amount of material on AHCA’s website, including a helpful “snapshot” of the MMA program that describes multiple aspects of the program including the plans that are available in each region.¹²⁰

ENROLLMENT POPULATION

As noted, most Medicaid recipients are required to receive their covered services through a managed care health plan.¹²¹ The voluntary enrollment population for the Florida MMA program, as well as the population excluded from the entire SMMC managed care program, are bulleted below.

¹¹⁹ 42 U.S.C. § 1315(a).

¹²⁰ http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf.

¹²¹ AHCA Model Contract, Attachment II at 36, Section III A. 1. (Mandatory enrollment populations). https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf

Who may (but need not) enroll in MMA?¹²²

- Recipients who have other creditable health care coverage, excluding Medicare
- Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455(48).
- Persons eligible for refugee assistance
- Residents of a developmental disability center
- Recipients enrolled in the home- and community-based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.
- Children receiving services in a prescribed pediatric extended care center
- Recipients residing in a group home facility licensed under Fla. Stat. Chapter 393

The following are exempt from participation in SMMC:¹²³

- Women who are eligible only for family planning services
- Women who are eligible only for breast and cervical cancer services
- Persons who are eligible for emergency Medicaid for aliens

ENROLLMENT PROCESS

AHCA automatically enrolls Medicaid-eligible individuals who are mandated to participate in the MMA into a health plan immediately after they are determined to be eligible for the program. At the time of their application for Medicaid, applicants will:

- receive information about managed care plan choices in their area;
- be informed of their options in selecting an authorized managed care plan;
- be provided the opportunity to meet or speak with a choice counselor; and
- be given the opportunity to indicate a plan choice selection if they are prepared to do so.

If an individual is determined to be eligible for Medicaid and a health plan has not been selected during the application process, they will be enrolled into a plan through auto-assignment. Through

¹²² Fla. Stat. § 409.972, AHCA Model Contract, Attachment II at 36, Section III. A. 2.
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf

¹²³ Fla. Stat. § 409.965.

this process, also referred to as “Express Enrollment,” health plan enrollment will be effective the same day that the recipient’s eligibility application is approved.¹²⁴

Selecting a Plan:

To find MMA health plan availability, see:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf

Choice counselors are available for questions and advice on which plan best suits each recipient’s particular health care needs. Choice counselors can be contacted at **1-877-711-3662**. Recipients with special needs have the option of requesting an in-person visit.

Recipients are encouraged to find a plan in which the individual’s doctors are in-network in order to maintain continuity of care.

MANAGED CARE SERVICES

What services must be covered?

At a minimum, all managed care plans must provide specified services that are enumerated in AHCA’s Model Contract, Section V¹²⁵:

AHCA’s web site has a useful section titled “[Adopted Rules & Service-Specific Policies](#).” The rule number and rule history for each covered service is provided, along with a PDF link to the coverage policies governing each service.¹²⁶

After enrollment into a health plan, recipients should receive a Member Handbook from their particular managed care provider detailing the services they are entitled to receive and information on how to contact the plan if a problem arises. The member handbook can also be found online or by calling the customer service representative for the particular plan.

Certain Medicaid services which are currently not covered by MMA health plans are available to eligible recipients through traditional fee-for-service Medicaid. *e.g.*, Applied Behavioral Analysis (ABA), Early Intervention Services (EIS), and Medical Foster Care.

What access standards apply to the health plans?

An important goal of the MMA program and the 2016 federal Medicaid managed care regulations is ensuring that plans have sufficiently robust networks so that enrollees can access services in a timely manner. The legislation implementing Florida’s MMA program specifically mandates that: “[t]he agency shall establish specific standards for the number, type, and regional distribution of providers

¹²⁴ https://ahca.myflorida.com/medicaid/statewide_mc/express_enroll.shtml

¹²⁵ AHCA Model Contract, Attachment I, Scope of Services (Feb 1, 2022)
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_I_Scope_of_Services_2022-02-01.pdf

¹²⁶ https://ahca.myflorida.com/medicaid/review/specific_policy.shtml

in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a region-wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan.”¹²⁷

Accordingly, “Network Adequacy Standards,” set forth in the Model Contract, MMA, Section VI, requires all health plans to maintain a provider network that is “sufficient in numbers to meet the access standards for specific medical [and behavioral] services for all recipients enrolled in the plan” in both urban and rural geographic areas.

APPOINTMENT ACCESS STANDARDS:

Urgent Care –

- within 48 hours if no prior authorization needed
- 96 hours if prior authorization needed

Non-Urgent Care –

- Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
- Within fourteen (14) days for initial outpatient behavioral health treatment.
- Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
- Within thirty (30) days of a request for a primary care appointment.
- Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.

TRAVEL TIME/DISTANCE STANDARDS¹²⁸

- Primary Care – within 20 miles/30 minutes (urban or rural)
- Specialists – (depending on the specialist) between 30-100 minutes/20-75 miles (urban); 30-110 minutes/20-90 miles (rural)
- Facilities/Hospitals – within 30 minutes/20 miles (urban or rural)
- Behavioral Health - within 30 minutes/20 (urban); 60 minutes/45 miles (urban)

CHANGING PLANS / DISENROLLING

Recipients may request disenrollment at any time via written or oral request to AHCA. Disenrollment is permitted as follows:

- For good cause, at any time.

¹²⁷ Fla. Stat. § 409.967(2)(c)(1).

¹²⁸ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_A_MMA-2022-02-01.pdf at 47.

- Without cause, for mandatory enrollees within the first 90 days after enrollment or after the broker sends notice of enrollment (whichever is later).¹²⁹
- Without cause, for voluntary enrollees at any time.

After 90 days, recipients may only change plans for “good cause.” After the 12-month period, recipients may change plans during the open enrollment period. To change their plan, beneficiaries can speak with choice counselors, who are available to assist recipients in selecting a plan that best fits their needs.

“Good cause” is required to change plans after 90 days

A Florida Medicaid recipient enrolled in a statewide MMA plan may request to change managed care plans at any time for good cause reasons. Requests are made by phone to the choice counselor at 1-877-711-3662.

The following reasons constitute good cause for disenrollment:¹³⁰

- 1) The enrollee does not live in a region where the Managed care Plan (MCP) is authorized to provide services.
- 2) The provider is no longer with the MCP
- 3) The enrollee is excluded from enrollment
- 4) A substantiated marketing violation has occurred.
- 5) The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
- 6) 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 MCP’s panel but is on the panel of another MCP.
- 7) The enrollee is in the wrong MCP as determined by the Agency.
- 8) The MCP no longer participates in the region.
- 9) The state has imposed intermediate sanctions upon the MCP, as specified in 42 CFR § 438.702(a)(4).
- 10) The enrollee needs related services to be performed concurrently, but not all related services are available within the MCP network, or the enrollee’s PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
- 11) The MCP does not, because of moral or religious objections, cover the service the enrollee seeks.
- 12) The enrollee missed open enrollment due to a temporary loss of eligibility.
- 13) Other reasons per 42 C.F.R. § 438.56(d)(2) and Fla. Stat. § 409.969(2), include, but are not limited to:

¹²⁹ See Rule 59G-8.600, Fla. Stat. § 409.969(2), 42 C.F.R. § 438.56
 See also https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2021-10-01/Attachment_II_Core_Contract_Provisions_2021-10-01.pdf at 37.

¹³⁰ Fla. Admin. Code R. 59G-8.600; see also 42 C.F.R. § 438.56.

- a. poor quality of care;
- b. lack of access to services covered under the Contract;
- c. inordinate or inappropriate changes of PCPs;
- d. service access impairments due to significant changes in the geographic location of services;
- e. an unreasonable delay or denial of service;
- f. lack of access to providers experienced in dealing with the enrollee's health care needs; or
- g. fraudulent enrollment.

FILING A COMPLAINT

Enrollees who are having trouble accessing services or who are encountering other problems with their managed care plan can file an official complaint. It is important that AHCA be made aware of these issues. It is also important that advocates provide assistance and documentation, and individual complaints can often be resolved through this process.

A complaint may be filed either online at https://apps.ahca.myflorida.com/smmc_cirts/ [**recommended for all issues**] or by speaking with a Medicaid representative by calling toll free 1-877-254-1055 to speak to a Medicaid representative.

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 provide their name and an email address or phone number.

AHCA uses this process both to resolve individual issues and to assist and help identify systemic problems.

Steps in filing an online complaint:

- First, under the **Complainant Information** section, the complainant must choose whether they are the Medicaid recipient, healthcare provider, or filing on behalf of the recipient or provider. The complainant can choose to either enter their name, email (if available), and phone number, or leave it blank.
- Next, under the **'Who is the complaint/issue about?'** section, the complainant will enter the recipient's name, gold card, SSN, or Medicaid number, the county of residence, whether a previous complaint has been filed with AHCA, the type of managed care plan, the name of the managed care plan, and whether the complainant has contacted the plan.
- Finally, under the **'Please complete all choices that relate to your issue'** section, the complainant can indicate the type of complaint, e.g., having trouble obtaining a specific service.

This last section allows the complainant to describe in detail the issue and why a complaint is being filed.

ADVOCATE'S TIP

It is always better if an advocate files the complaint. If someone other than the individual receiving services files the complaint, however, be sure that the filing person also files an Authorized Representative form to ensure that AHCA will speak to them. This [document](#) provides step-by-step instructions for filing a complaint regarding a Medicaid managed care plan.

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.¹³¹ 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.¹³²

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 based on “requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit” (e.g., 2 hours of speech therapy/week for 6 months were prescribed and the plan approved only 1 hour/week for one month);
- Failure to provide service in a timely manner as defined by the state;
- Failure of plan to act within required timeframes for resolution of grievance or appeal; and
- Denial in whole or in part of payment for a service of a request to dispute cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.¹³³

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.

¹³¹ 42 C.F.R. §§ 438.228, 438.56(d)(5), 59G-8.600(3)(b)

¹³² 42 C.F.R. § 438.400(b); Fla. Admin. Code R. 59G-1.100(2)(b) (definition of “grievance”)

¹³³ 42 C.F.R. § 438.400(b); Fla. Admin. Code R. 59G-1.100(2)(b) (definition of “adverse benefit determination”).

What is the time standard for filing a grievance or appeal?

A grievance can be filed at any time, and an appeal can be filed within 60 calendar days from the date of the ABD.¹³⁴

Is there a statutory right to a fair hearing?

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

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 in the plan appeal process.¹³⁵

Are there any exceptions to the exhaustion requirement?

Yes. 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's appeal process and can request a state fair hearing.¹³⁶

What constitutes adequate notice?

The notice must include the following information:

- 1) The ABD that has been made or intended
- 2) Reason(s) for the ABD (including the right to copies of all documents relevant to the decision, free of charge)
- 3) Right to request an appeal, including:
 - Information on exhausting one level of appeal
 - Right to request a state fair hearing
- 4) Process for appeal
- 5) Circumstances for an expedited appeal and how to request
- 6) Right to have benefits continue pending resolution of appeal, including:
 - How to request continued benefits
 - Circumstances under which enrollee may be required to pay

¹³⁴ 42 C.F.R. § 438.402(c)(2);

[https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment II Core Contract Provisions 2022-02-01.pdf](https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment%20II%20Core%20Contract%20Provisions%202022-02-01.pdf) at 84,86

¹³⁵ 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](https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment%20II%20Core%20Contract%20Provisions%202022-02-01.pdf) at 89.

¹³⁶ 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.
[https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment II Core Contract Provisions 2022-02-01.pdf](https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment%20II%20Core%20Contract%20Provisions%202022-02-01.pdf) at 88.

Additionally, the notice must be accessible to individuals with disabilities or limited English proficiency.¹³⁷

What time standards apply to various notices?

- 1) If the action concerns a termination, suspension, or reduction of a benefit - written notice must be sent 10 days before the date of action.
- 2) If the action concerns a denial of payment - notice must be sent at time of action affecting claim.
- 3) If the action concerns a standard service authorization decision that denies or limits services - notice must be sent within 14 days.
- 4) If an expedited service authorization has been requested - notice must be sent within 72 hours.
- 5) 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.¹³⁸

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)).

Is there a right to an expedited appeal?

Yes, if the standard resolution “could seriously jeopardize the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.”¹³⁹

Filing and handling a grievance or appeal with plan

¹³⁷ 42 C.F.R § 438.10.

¹³⁸ 42 C.F.R. § 438.404(c)(5).

¹³⁹ 42 C.F.R. § 438.410; Model Contract, Attachment II, at 89, Section VII, H., https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf.

Grievances or 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).¹⁴⁰ The best practice is to file in writing with the plan.¹⁴¹

The plan must provide written notice acknowledging the receipt of the grievance or appeal within five business days.¹⁴²

Where to file fair hearings and who are the parties?

Medicaid appeals related to services for persons enrolled in a managed care plan are directed to AHCA. See Fla. Stat. § 409.285(2).

The managed care organization is the respondent, and “upon request by AHCA, the Agency may be granted party status by the Hearing Officer.”¹⁴³

How to ensure continuation of benefits pending appeal and state fair hearing if the ABD is a termination, reduction, or suspension of current services?

If an adverse action is a termination, suspension, or reduction of a previously authorized medical service, the enrollee has the right to receive continued coverage of the medical service 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 the following occur:

- Appeal involves termination, suspension, or reduction of previously authorized service
- Services 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.¹⁴⁴

¹⁴⁰ Model Contract, Attachment II, at 86, Section VII, F. 1. B., [https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment II Core Contract Provisions 2022-02-01.pdf](https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment%20II%20Core%20Contract%20Provisions%202022-02-01.pdf); see also 42 C.F.R. § 438.406(b)(3).

¹⁴¹ See, e.g., 42 C.F.R. § 438.406 for information related to handling grievances and appeals.

¹⁴² Model Contract, Attachment II at 84, Section VII, D. 2., [https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment II Core Contract Provisions 2022-02-01.pdf](https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment%20II%20Core%20Contract%20Provisions%202022-02-01.pdf); see also, 42 C.F.R. § 438.406 (b)(1).

¹⁴³ Fla. Admin. Code R. 59G-1.100(4)(b).

¹⁴⁴ Model Contract, Attachment II at 90, Section VII, J. 11. B., [https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment II Core Contract Provisions 2022-02-01.pdf](https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment%20II%20Core%20Contract%20Provisions%202022-02-01.pdf).

If the beneficiary is provided with continued coverage of the service and ultimately loses the appeal, the cost of the service can be recouped.¹⁴⁵

What are enrollee rights in grievances and appeals?

Enrollees have the right to:

- make legal and factual arguments in person and in writing. 42 C.F.R. § 438.406(b)(4)
- present evidence, including new evidence not available at time of decision. 42 C.F.R. § 438.406(b)(5)
- review medical records and case files free of charge and in advance of the hearing.

The Model Contract includes all the above except the right to review of medical records and file free of charge.¹⁴⁶

Discovery and subpoenas

Florida is one of the only states that allows full discovery in 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 purpose of discovery and to prevent delay."¹⁴⁷

ADVOCATE TIP:

It cannot be overstated how helpful discovery can in Medicaid fair hearings. Medicaid recipients and their advocates would do well to liberally utilize discovery in their litigation of claims in grievances and appeals, as it is likely to result in far more advantageous outcomes. Discovery rights include the usual discovery tools of:

- requests for production of documents
- requests for admission
- depositions

*What are the time standards for filing and resolving grievances and appeals and what notice is required?*¹⁴⁸

¹⁴⁵ Model Contract, Attachment II at 88, Section VII. F. 1. I., https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf; see also 42 C.F.R. § 438.420(d).

¹⁴⁶ 42 C.F.R. § 438.406(b)(4)(5); compare Model Contract, Attachment II, Exhibit II Core Contract Provisions, Section IV.C. 5.d. at 86. https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf (Contract includes all the provisions in federal regulation except the right to review of medical records and file free of charge).

¹⁴⁷ Fla. Admin. Code R. 59G-1.100 (13)(a).

¹⁴⁸ Model Contract, Attachment II at 87, Section VII. F. 1., https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf, 42 C.F.R. § 438.402(c)(2)(ii).

Florida’s filing and resolution time frames are as follows:

- Grievance – can be filed at any time and must be decided within 90 days
- Standard appeals – filed orally or in writing within 60 days from the date of the adverse benefit determination and must be resolved within 30 days
- Expedited appeals – file written appeal within 10 days of oral request and must be resolved within 72 hours.

Type of Action	Filing Time Frame	Resolution Time Frame
Plan Appeal	60 days from the date of the adverse benefit determination	30 days from the day the health plan receives the plan appeal
Expedited Appeal	60 days from the date of the adverse benefit determination	72 hours after the health plan receives the expedited appeal
Grievance	Can be filed at any time	90 days from the day the health plan receives the grievance
Fair Hearing	120 days after the enrollee receives notice that the health plan is upholding the adverse benefit determination (i.e., after the plan appeal is decided)	90 days from the date the enrollee filed the plan appeal (with some exceptions)

Note: 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 best interests of the enrollee.

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.¹⁴⁹

RELEVANT AUTHORITY

There are multiple authorities enumerated below which relate to Florida’s MMA program, including federal and state statutes and regulations (rules); contractual provisions between AHCA and the managed care plans, and the Special Terms and Conditions (STC) agreement between the state and federal government in the Section 1115 Waiver.

¹⁴⁹ See 42 CFR 438.10(c)(4)(ii); Model Contract, Attachment II, Exhibit II Core Contract Provisions, at 89, Section VII. I. 1. https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf

Federal Regulations

The federal Medicaid Managed care regulations represent a significant development for Medicaid beneficiaries. After receiving voluminous comments from advocates, providers, and state governments, CMS issued final regulations in April 2016.

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 (LTC) program.¹⁵⁰

AHCA's Model Contract

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

- Attachment I re: Scope of Services, February 1, 2022
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_I_Scope_of_Services_2022-02-01.pdf
- Attachment II re: Core Contract Provisions, February 1, 2022
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf
- Attachment II, Exhibit II-A re: MMA Program, February 1, 2022
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Exhibit_II_A_MMA-2022-02-01.pdf

Section 1115 MMA Program Special Terms and Conditions

Under § 1115 of the Social Security Act, states can request authority to waive some, but not all, portions of the Medicaid Act. The request is made to CMS through an § 1115 Waiver request. CMS has discretion to approve or deny the waiver request, and if the Waiver is approved, the Special Terms and Conditions (also referred to as STCs) set forth the nature of CMS' involvement and the state's obligations throughout the waiver period. The current STCs are attached to this January 15, 2021, CMS letter to AHCA approving the requested waiver extension. *See* https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_MMA_Extension_STCs_1.15.2021.pdf

Florida Administrative Rules

¹⁵⁰ See Florida Health Justice Project, *The Advocate's Guide to the Florida Long-Term Care Medicaid Waiver*, <https://www.floridahealthjustice.org/guide-to-long-term-care-medicaid-waiver.html>.

The state's relevant administrative rules pertaining to various covered medical services are found at Fla. Admin. Code Rules (or F.A.C.) 59G-4.010 *et seq.*

Also relevant is the state rule pertaining to plan disenrollment at F.A.C. 59G-8.600.

Finally, fair hearings related to Medicaid managed care are conducted by AHCA as described at 59G-1.1.