FLORIDA HEALTH
JUSTICE PROJECT

ADVOCATE'S GUIDE:

FLORIDA MEDICAID PROGRAM

3rd Edition
2025

ACKNOWLEDGMENTS

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Updated Acknowledgements

Advocate Guides need to be regularly updated: laws change and rules change, waiver documents are updated, managed care contracts are amended. This 3rd Edition would not have been possible without the incredible hard work and dedication of my colleague, Haley Brown.

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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[1]:

- 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 managed care works
- What to do if services are denied, delayed, terminated, or reduced

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/caretakers).[2]

Half a century later, the Affordable Care Act (ACA) 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)[3], it also required states to expand their Medicaid program to provide coverage for low-income adults under 133% of FPL.[4]

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[1] This Guide is intended for use by legal services and pro bono attorneys assisting low-income clients, as well as pro se litigants. 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, for example, Institutional Care Medicaid, or other Home-and Community-Based Waivers.

[2] DEP'T. OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., MILESTONES 1937 TO 2015 2 (July 2015), http://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf.

[3] 26 U.S.C. § 36B (c)(1)(A); *Poverty Guidelines*, U.S. DEP'T. OF HEALTH AND HUM. SERVS., ASSISTANT SEC'Y FOR PLAN. AND EVALUATION (2025) https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

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

Shortly after the passage of the ACA, Florida and twenty-six other states sued the federal government, alleging, *inter alia,* that this "Medicaid expansion" was unconstitutional.[5] In *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court ruled that requiring states to expand their Medicaid programs to cover low-income adults who did not meet a categorical connection was "overly coercive."[6] The Court's decision meant that each state would decide whether to extend coverage to this group.

As of 2025, Florida is one of ten states that has not accepted federal funding for coverage of the Medicaid expansion population.[7] As a result, approximately half a million low-income Floridians have no path to affordable coverage.[8] They fall into what is referred to as the "coverage gap."

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.

SOURCES OF FEDERAL AND STATE AUTHORITY

Federal Law:

- 42 U.S.C. §§ 1396 – 1396w-8
- 42 C.F.R. §§ 430 – 457

Federal Policy:

- Centers for Medicare and Medicaid Services (CMS)
- "Dear State Medicaid Director" Letters

State Law:

- Florida Statutes §§ 409.901-409.9531
- Florida Administrative Code 59G
- Florida Administrative Code 65A-1

[5] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 519 (2012).

[6] *Id.* at 580.

[7] *See* FLA. HEALTH JUST. PROJECT, OPPOSITION, INACTION AND OBSTRUCTION: A HISTORY OF FLORIDA'S FAILURE TO PASS MEDICAID EXPANSION (June 8, 2022), https://floridahealthjustice.org/wp-content/uploads/2022/07/medicaid-expansion-history-6.8.22-update.pdf (showing a chronology of the Florida Legislature's opposition to Medicaid expansion, including a ballot initiative).

[8] *See How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?*, KFF (Feb. 25, 2025), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (discussing the coverage gap that includes parents or caregivers whose incomes are above Florida's eligibility for Medicaid, which is only about 30% of the federal poverty level, but below the poverty line, 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).

State Policy:

- Florida Department of Children and Families ESS Program Policy Manual[9]
- Florida Medicaid Service Specific Policies[10]
- Florida Department of Children and Families Policy Transmittals[11]

At the federal level, Medicaid is administered by the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (USDHHS). CMS divides the states into ten regions, with a regional office for each. Florida is in Region IV.[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).[13]

Among other things, 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 regarding the COVID-19 public health emergency (PHE).[14]

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.[15] In Florida, the guaranteed funding formula means

[9] *ESS Program Policy Manual*, *supra* note 2.

[10] *Adopted Rules–Service Specific Policies*, FLA. AGENCY FOR HEALTH CARE ADMIN. (2025), https://ahca.myflorida.com/medicaid/review/specific_policy.shtml.

[11] *See* FLA. HEALTH JUST. PROJECT, DCF TRANSMITTALS 2012-2025, https://app.box.com/s/n8tjt3hlsemoix7q0or9ivf207oz5edo/folder/318518335059 (hosting an incomplete library of DCF policy transmittals, collected and archived by Florida Health Justice Project).

[12] Ctrs. for Medicare & Medicaid Servs., *CMS Regional Offices*, MEDICAID.GOV (2025), https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices.

[13] FLA. STAT. § 409.902(1) (2025).

[14] *See, e.g., ARCHIVED: Unwinding and Returning to Regular Operations after COVID-19*, CTRS. FOR MEDICAID & MEDICARE SERVS., https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19.

[15] The federal government's share of most Medicaid expenditures is called the Federal Medical Assistance Percentage, or "FMAP". *See* Congressional Research Service, *Medicaid's Federal Medical Assistance Percentage (FMAP)*, CONGRESS.GOV (Apr. 2, 2025), https://www.congress.gov/crs-product/R43847#:~:text=Generally%20determined%20annually%2C%20the%20FMAP,state%20and%20is%20generally%2050%25.

that for every $1 spent on Medicaid-covered services for eligible enrollees, the federal government provides approximately $0.57.[16]

SECTION TWO: ELIGIBILITY

ELIGIBILITY OVERVIEW

Under federal law, states *must cover* specified mandatory coverage groups, and states *may cover* additional categories that meet eligibility requirements.[17] Eligible individuals who qualify for coverage under any mandatory or optional category are known as the "categorically needy."[18]

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 "SSI-related" (based on age or disability) or "family-related."

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."[19]

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[16] *See* 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, 2024 through September 30, 2025, 88 Fed. Reg. 223 (Nov. 21, 2023) https://www.federalregister.gov/documents/2023/11/21/2023-25636/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for; *See also Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates*, KFF (Feb. 13, 2025), https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/#:~:text=What%20is%20the%20proposed%20policy,adults%20in%20the%20Medicaid%20expansion (discussing if 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%).

[17] 42 U.S.C. § 1396a(a)(10)(A)(i).

[18] 42 U.S.C. § 1396a(a)(10)(A); 42 C.F.R. §§ 435.4, .100-.172, .200-.236; CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL CHAPTER 3- ELIGIBILITY, https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927 (discussing §§ 3300-3493 & 3500-3596); FLA. STAT. §§ 409.903, .904 (2025).

[19] 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. 435.4; 42 CFR §§ 435.300-.350; CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL CHAPTER 3- ELIGIBILITY, https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927 (discussing § 3600-3645.6); FLA. STAT. § 409.904(2) (2025); FLA. ADMIN. CODE R. 65A-1.703(3).

MANDATORY COVERAGE GROUPS[20]

- Low-income parents & caretakers
- Children aged 0-18
- Individuals aged 19-20
- Pregnant women (post-partum coverage for 12 months)[21]
- SSI recipients, including Protected Medicaid & "Pickle People" [22]
- Medicare Savings Programs (MSPs)
- Youth to age 26 who have aged out of foster care[23]
- Working disabled[24]

OPTIONAL COVERAGE GROUPS[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 care
- Individuals eligible for home and community-based services through the long-term care (LTC) waiver or iBudget waiver

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[20] FLA. STAT. § 409.903 (2025); 42 U.S.C. § 1396a(a)(10)(A)(i). FLA. ADMIN. CODE R. 65A-1.703, .710 (discussing Florida administrative rules listing family-related and SSI-related coverage groups include both mandatory and optional coverage groups).

[21] *See* FLA. STAT. § 409.903(5) (reflecting legislative changes due to Florida's submission of a Section 1115 application On September 3, 2021 to amend its Medicaid Program which was approved by CMS on May 25, 2022). *See also* Ctrs. for Medicare & Medicaid Servs., *Florida Managed Medical Assistance*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81311.

[22] *See* Jennifer Lav & Jules Lutaba, *A Quick and Easy Method of Screening for Medicaid Eligibility Under the Pickle Amendment*, NAT'L HEALTH L. PROGRAM (Dec. 16, 2024), https://healthlaw.org/resource/a-quick-and-easy-method-of-screening-for-medicaid-eligibility-under-the-pickle-amendment-2025-update/ (stating a description of "Pickle People").

[23] 42 C.F.R. § 435.150(b); FLA. ADMIN. CODE R. 65A-1.703(2)(d).

[24] *See* 42 U.S.C. 1396d(s) (working people with disabilities under 1619(b) are listed in the federal Medicaid statute as a "mandatory" coverage group); *See also* 42 U.S.C. § 1396a(a)(10)(A)(ii); *See also e.g, Working People with Disabilities*, FLA. AGENCY FOR HEALTH CARE ADMIN., http://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/working-people-with-disabilities.

[25] FLA. STAT. § 409.904 (showing Florida administrative rules listing family-related and SSI-related coverage groups include both mandatory and optional coverage groups); *see* FLA. ADMIN. CODE R. 65A-1.703, 710.

- Emergency Medicaid for Aliens (EMA)

When Does Eligibility Begin?
Under current federal law, eligible applicants are entitled to 90 days of retroactive eligibility.[26] This period of retroactive eligibility is referred to as "RME." Florida has received permission from the federal government to limit the 90-day RME period to pregnant women and children under 21 years of age.[27] For nonpregnant adults in Florida, eligibility begins on the first day of the month in which the individual's application was filed.[28]

Note: The budget reconciliation package, H.R. 1, signed into law on July 4, 2025, limits the effective date for retroactive coverage of Medicaid benefits to the month preceding the month in which the individual applied for Medicaid, beginning December 31, 2026.[29]

CONTINUOUS ELIGIBILITY FOR CHILDREN AND NEW MOTHERS

In 2021, the Florida Legislature passed a bill that extended postpartum coverage to a full 12 months after birth.[30]

As of January 2024, states are required to provide 12 months of continuous eligibility for children under the age of 19 in Medicaid and CHIP regardless of changes in circumstances."[31]

FAMILY-RELATED MEDICAID ELIGIBILITY

Florida's Family-Related Medicaid Groups include the following groups[32]:

- Infants aged 0-1

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[26] 42 U.S.C. § 1396a(a)(34).

[27] CENTERS FOR MEDICARE & MEDICAID SERVICES, WAIVER NO. 11-W-00206/4 FLORIDA MANAGED MEDICAL ASSISTANCE (Jan. 15, 2021), https://ahca.myflorida.com/content/download/10870/file/FL_MMA_Extension_STCs_1.15.2021.pdf (Florida received approval from the federal government through a Section 1115 waiver to waive the RME requirement in the Medicaid statute for non-pregnant adults over 21 to limit coverage to one month, further restricting the right to RME).

[28] FLA. STAT. §§ 409.904 (12)(a)-(b), 409.906.

[29] H.R. 1, 119th Cong. (2025), Pub. L. No. 119-21,139 STAT. 72, at § 44122.

[30] *See* FLA. STAT. § 409.903(5) (2021) (Prior to 2022, postpartum coverage was limited to 60 days).

[31] Ctrs. for Medicare & Medicaid Servs., *Continuous Eligibility for Medicaid and CHIP Coverage*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage.

[32] *See* FLA. STAT. § 409.903 (2025); FLA. ADMIN. CODE R. 65A-1.703. *See also ESS Program Policy Manual*, *supra* note 2 (Note: there are additional optional coverage groups, *e.g.* HBCS and PACE).

- Children aged 1-5
- Children aged 6-18
- Individuals aged 19-21
- Pregnant Women
- Parents/Caretakers of minor children

The eligibility for each group varies based on the household income. There is no asset test for family-related Medicaid eligibility.[33]

For children, the income limit goes down gradually as the child gets older. For example, (based on 2025 poverty guidelines), in a household of 3, the monthly income limit[34]:

- For an infant under age 1 would be $4,686.00
- For a child aged 1–5, it would be $3,220.00
- For a child aged 6-18, it would be $3,065.00

ADVOCATE'S TIP

Advocates should bookmark and/or make a copy of FHJP's Family-Related Medicaid Income Limits chart.[35] This chart is a useful tool for quickly determining the relevant income limit for different family-related coverage groups. It is based on DCF's family-related Medicaid Income Limits chart and eliminates the need for adding the relevant disregards to each coverage category

INDIVIDUALS AGED 19 & 20

As noted above, family-related Medicaid income eligibility limits *gradually* decrease as the child gets older. But once a child turns 19, the limit *significantly decreases*. On the day of the child's 19th birthday, Medicaid eligibility drops from 138% of the federal poverty level (FPL) to less than 30% of FPL, or $597.00/month in a household of three (based on 2025 FPL).[36]

[33] FLA. ADMIN. CODE R. 65A-1.708(2).

[34] FLA. DEP'T OF CHILDREN AND FAMILIES, ESS PROGRAM POLICY MANUAL APPENDIX A-7 FAMILY-RELATED MEDICAID INCOME LIMIT CHART (2025), https://www.myflfamilies.com/sites/default/files/2025-05/Appendix_A-7-Family-Related_Medicaid_Income_Limit_Chart.pdf [hereinafter A-7 FAMILY-RELATED MEDICAID INCOME LIMIT]

[35] *See* FLA. HEALTH JUST. PROJECT, 2025 ESTIMATED FLORIDA FAMILY RELATED MEDICAID INCOME LIMITS 1 (Mar. 2025) https://floridahealthjustice.org/wp-content/uploads/2025/03/2025-Medicaid-Eligibility-Levels-Estimated.pdf.

[36] A-7 FAMILY-RELATED MEDICAID INCOME LIMIT, *supra* note 34.

However, a 19 or 20 year-old may remain eligible for Medicaid as a "household of one," even if the individual is still living at home.[37]

WHEN CAN A 19 OR 20 LIVING AT HOME BE ELIGIBLE FOR MEDICAID:

- If the individual's income is below the limit for adults
- If the individual is not claimed as a dependent by their parent/caretaker
- If the individual is not a full-time student

There are a number of considerations that the individual and their parents would want to consider: is it in the best interest of the family for the 19 or 20 year old to remain on the parent's tax return as a dependent; does the youth turning 19 have medical issues previously covered by Medicaid and needs insurance; is Medicaid the best or only option for ongoing coverage?[38]

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").[39] For additional information, the National Health Law Program has provided a comprehensive guide to understanding MAGI.[40]

Generally, MAGI includes the adjusted gross income plus certain exclusions such as any tax-exempt Social Security benefits, tax-exempt interest, and untaxed foreign income. [41]

MAGI also includes (non-exhaustive):[42]

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

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[37] *See* FLA. ADMIN. CODE R. 65A-1.705 (noting that the filing unit includes 19 or 20 year-olds if the individual is a full-time student).

[38] Fla. Health Just. Project, *Preparing for The Public Health Emergency's "Unwind" Special Considerations for 19 & 20 Year Olds*, YOUTUBE (Dec. 2022), https://www.youtube.com/watch?v=qCKpNq02DDU&t=2s.

[39] 42 C.F.R. § 435.600*; see* A-7 FAMILY-RELATED MEDICAID INCOME LIMIT, *supra* note 34. (showing DCF Family-related income eligibility chart specifying the income limits under each category per household size).

[40] Wayne Turner, *Advocate's Guide to MAGI (Updated Guide for 2018)*, NAT'L HEALTH L. PROGRAM, (Aug. 22, 2018), https://healthlaw.org/resource/advocates-guide-to-magi-updated-guide-for-2018/.

[41] 42 C.F.R. § 435.603(e); 26 U.S.C. § 36B(d)(2)(B); 26 U.S.C. § 911 (citing exclusions which are added back in for MAGI under 26 U.S.C. § 36B(d)(2)(B)(i)); Cntrs. for Medicare & Medicaid Servs., *Count income & household size*, HEALTHCARE.GOV, https://www.healthcare.gov/income-and-household-information/income (discussing "What to Include as Income"); FLA. ADMIN. CODE R. 65A-1.707.

[42] *Id.*

MAGI does not include (non-exhaustive):[43]

- 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.[44] In addition, scholarships, awards, and fellowship grants are not included as income unless they are used for living expenses rather than for education.[45]

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.[46]

SSI-RELATED MEDICAID ELIGIBILITY

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

- 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
- Breast and Cervical Cancer Treatment (BCC).
- Familial Dysautonomia (FD)
- iBudget[47]
- Working People w/Disabilities[48]

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[43] *Id.*

[44] 42 C.F.R. § 435.603(e)(1).

[45] 42 C.F.R. § 435.603(e)(2).

[46] 42 C.F.R. § 435.603(d); FLA. ADMIN. CODE R. 65A-1.702-.708, 1.716.

[47] FLA. ADMIN. CODE R. 65A-1.710; *see also SSI-Related Medicaid Programs Fact Sheet*, FLA. DEP'T OF CHILDREN & FAMILIES, 8 (2025), https://www.myflfamilies.com/service-programs/access/docs/ssifactsheet.pdf.

[48] *See* 42 U.S.C. § 1382h (regarding Section 1619(b) of the Social Security Act provides continuing Medicaid for recipients of SSI who return to work and earn income too high for SSI payments, but their earnings are insufficient to cover the cost of their lost Medicaid); *See also* 42 U.S.C. 1396d(s) (working people with

ADVOCATE'S TIP

Advocates should bookmark, and/or make a copy of DCF's SSI-Related Medicaid Coverage Group Financial Eligibility, found at Appendix A-9. The income and asset limits vary depending on the particular coverage groups.[49]

Resources are defined as assets that a person owns and has the authority or power to convert to cash or make available for her support.[50] 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 insurance policies are excluded.[51]

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,[52] and trust funds.[53] If an individual can prove that something, which ordinarily is counted, is unavailable, it should not be counted.[54]

MEDICARE SAVINGS PROGRAMS

Additional SSI-related coverage groups include those who are enrolled in a Medicare Savings Program, also called an "MSP." Depending on the program, eligible individuals receive help with

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disabilities is listed in the federal Medicaid statute as a "mandatory" coverage group). *See also* FLA. DEP'T OF CHILDREN AND FAMILIES, ESS PROGRAM POLICY MANUAL APPENDIX A-9 SSI-RELATED MEDICAID COVERAGE GROUPS FINANCIAL ELIGIBILITY STANDARDS 1 (Jan. 2024), https://www.myflfamilies.com/sites/default/files/2024-01/Appendix%20A-9.pdf (this coverage group is not listed in Fla. Stat. §§ 409.903 or 409.904 or the Florida Administrative Code for SSI coverage groups; however, this coverage group is included in the DCF Financial Eligibility Standards Chart A).

[49] FLA. ADMIN. CODE R. 65A-1.712.

[50] 20 C.F.R. § 416.1201(a).

[51] 42 U.S.C. § 1382b(a).

[52] *Program Operations Manual System SI 01130.300 Developing Life Insurance Policies*, SOC. SEC. ADMIN. (Nov. 14, 2013), https://secure.ssa.gov/poms.nsf/lnx/0501130300 (discussing § C.1 consider "the resource value of a life insurance policy to be its cash surrender value (CSV), not its face value (FV)").

[53] *Program Operations Manual System SI 01120*.200, SOC. SEC. ADMIN. (May 6, 2024), (discussing § D.1.a. "[t]rust principal is a resource for SSI purposes if a trust beneficiary (applicant, recipient, or deemor) has legal authority to revoke or terminate the trust and then use the funds to meet their food or shelter needs. . . The trust principal is also a resource for SSI purposes if the trust beneficiary can direct the use of the trust principal for their support and maintenance under the terms of the trust. Additionally, if the trust beneficiary can sell their right to receive payments from the trust, that right is a resource.") (Author's Note: this *Guide* is not addressing other resource related provision including, e.g., special needs trusts).

[54] 20 C.F.R. § 416.1201(a)(1).

Medicare's out-of-pocket costs, including premiums.[55] These programs include QMB, SLMB, and QI-1:

- The **Qualified Medicare Beneficiary (QMB)** program covers both Part A and Part B premiums and copays ($1,305/month income limit for a household of one).
- The **Specified Low Income Medicare Beneficiary (SLMB)** program covers Part B premiums only ($1,565/month income limit for a household of one).
- The **Qualifying Individual 1 (QI1)** program covers Part B premiums only ($1,761/month income limit for a household of one).[56]

For all programs, the asset limit is $9,660 for a household of one.[57]

Calculating eligibility
In early 2024, DCF adopted a helpful change in the process for determining MSP eligibility.[58] This change followed updated guidance from CMS.[59] This change allows counting all relatives in the household who receive at least half of their financial support from the applicant in determining the household size, while at the same time not counting the income or assets of other household members (with the exception of the spouse).[60]

Prior to the change, household size was limited to the applicant and those whose income was deemed to the applicant, typically just the spouse. Since the eligibility income limit increases as the household size increases, this change makes it easier for more MSP applicants to gain eligibility.

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[55] Ctrs. for Medicare & Medicaid Servs., *Medicare Savings Programs*, MEDICARE.GOV, https://www.medicare.gov/basics/costs/help/medicare-savings-programs.

[56] FLA. ADMIN. CODE R. 65A-1.712, .713; FLORIDA DEP'T. OF CHILD. AND FAMILIES, *Medicare Savings Programs (MSPs) and Low-Income Subsidy (LIS) Coverage Groups* 1 (Apr. 2025), https://www.myflfamilies.com/sites/default/files/2025-02/Appendix%20A-9.1.pdf.

[57] *Id.*

[58] *See* Fla. Dep't. of Child. and Families, TRANSMITTAL NO.: P-24-01-0001, (Jan. 26, 2024) https://app.box.com/s/n8tjt3hlsemoix7q0or9ivf207oz5edo/file/1845473031742 (discussing Florida's positive change followed promulgation of the final MSP rule by CMS in 2023); *See also* FLA. DEP'T OF CHILD. AND FAMILIES, PROGRAM POLICY MANUAL 2000 COVERAGE GROUPS 36 (2025) (discussing § 2240.0606.05 Definition of Family Members considered as Household Members (MSP)); Fla. Health Just. Project, *Important Change To Family Size Under Florida's Medicare Savings Programs* (Oct. 2025) https://floridahealthjustice.org/publications/important-change-to-family-size-under-floridas-medicare-savings-programs/.

[59] Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment, 88 Fed. Reg. 182 (Sept. 21, 2023).

[60] *Important Change To Family Size Under Florida's Medicare Savings Programs*, *supra* note 58.

ADVOCATE'S TIP

For low-income Floridians on Medicare, it is very important to look at the household size and eligibility chart in determining if an individual is eligible for an MSP. This is important because even though Florida has adopted this policy change, the change has not been operationalized, *i.e.*, DCF's MSP application, last updated in 2006, does not collect the number of individuals in the household.[61]

IMMIGRANTS & MEDICAID

To be eligible for Medicaid coverage, an individual must be a U.S. citizen or have a "qualified" immigration status. With specified exceptions, qualified non-citizens are prohibited from receiving Medicaid for the first five years after receipt of their qualifying immigration status.[62] There is no coverage for unqualified immigrants except through Emergency Medical Assistance to Aliens (EMA).[63]

Currently, qualified non-citizens not subject to the five-year wait include[64]:

- Refugees
- Asylees
- Individuals who are veterans or on active-duty military
- Spouses and children of veterans or active military personnel
- Indians born in Canada
- Cuban or Haitian entrants
- Amerasian immigrants
- Trafficking victims and his or her spouse, child, sibling, or parent
- Immigrants whose deportation is being withheld
- Battered non-citizens, spouses, children, or parents
- Lawfully residing children under the age of 19[65]

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[61] Fla. Dep't. of Child. And Families, *CF-ES 2282, Medicaid/Medicare Buy-In Application*, (July 2006), https://share.google/KYR9rUyDdFCWRQAoP.

[62] 8 U.S.C. § 1613(a); 42 C.F.R. § 435.4062(a)(2).

[63] 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) (2025); FLA. ADMIN. CODE R. 59G-1.050(4).

[64] 8 U.S.C. §§ 1612, 1613(b); Fla. Stat. § 414.095(3) (2025); Fla. Dep't of Children and Families, Program Policy Manual 1400 Technical Requirements (MFAM/MSSI) (2025) https://ffic.myflfamilies.com/manual/1430.pdf (discussing § 1430 Family Related Medicaid & § 1440 SSI-Related Medicaid, State Funded Programs).

[65] FLA. STAT. § 409.904(8).

The 2025 budget reconciliation package, H.R. 1, included major changes to Medicaid eligibility for immigrants.[66] Significantly, H.R. 1 narrows the definition of qualified non-citizens who are eligible for Medicaid and CHIP effectively eliminating coverage for refugees, asylees, and other humanitarian categories as of October 1, 2026.

STATE RESIDENCE

Medicaid eligibility is dependent on state residency.[67] 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.[68]

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.[69]

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[70]:

- Have a Social Security number or have applied for one;[71]
- Provide verification of all health insurance;
- Assign to the state all rights to payment for health care from any third parties;

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[66] H.R. 1, 119th Cong. (2025), Pub. L. No. 119-21.

[67] 42 C.F.R. § 435.403; FLA. ADMIN. CODE R. 65A-1.705(1)(b); FLA. DEP'T OF CHILD. AND FAMILIES, PROGRAM POLICY MANUAL 1400 TECHNICAL REQUIREMENTS (MFAM/MSSI) 14, 40 (2025), https://ffic.myflfamilies.com/manual/1430.pdf (discussing §§ 1430.0300, 1440.0300).

[68] *Id.*

[69] *Id.*

[70] *See* Florida Dep't. of Child. and Families, TRANSMITTAL NO.: P-25-07-0003 (July 22, 2025) https://app.box.com/s/n8tjt3hlsemoix7q0or9ivf207oz5edo/file/1932416354155 (Prior to July 2025, Medicaid applicants – including individuals subject to renewals – were required to apply for other benefits – *i.e.,* pensions, retirement, social security benefits, disability benefits, etc.—in addition to their Medicaid application).

[71] *See* FLA. ADMIN. CODE R. 65A-1.302; FLA. DEP'T OF CHILD. AND FAMILIES, PROGRAM POLICY MANUAL 1400 TECHNICAL REQUIREMENTS (MFAM/MSSI) 12–13 (2025), https://ffic.myflfamilies.com/manual/1430.pdf (discussing §§ 1430.0200, 1430.0204, that the DCF program manual does not provide for any exceptions of failure to provide SSN); 42 C.F.R. § 435.910 (discussing that the federal regulation policy allows for an exception based on a "well established religious objection"); *See also* 42 C.F.R. § 435.910(h); FLA. ADMIN. CODE R. 65A-1.302(3) (showing that the state rule allows for "good cause failure to provide SSN").

- 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 child;[72] and
- Not be residing in a penal institution.[73]

SECTION THREE: APPLICATIONS, DETERMINATIONS, AND APPEALS

Individuals who meet the state's requirements for eligibility are entitled to 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."[74]

In Florida, the Department of Children and Families (DCF) determines eligibility.[75] There is a "no wrong door" policy for applicants,[76] which means that if someone applies to an agency other than DCF, 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. 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 MyACCESS Florida website, or online at the Health Insurance Marketplace website.[77]

DCF has 45 days to process the application and issue an eligibility determination.[78]

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[72] *See* 42 U.S.C. § 1396d(r)(5); FLA. ADMIN. CODE R. 65A-1.702(5) (This requirement only applies to parents; pregnant women are not required to cooperate with Child Support Enforcement to be eligible for Medicaid. Cooperation is also not required in Medicaid cases where benefits are only requested for a child).

[73] PROGRAM POLICY MANUAL 1400 TECHNICAL REQUIREMENTS, *supra* note 71, at 21 (discussing § 1430.1103).

[74] *See, e.g.*, Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981).

[75] FLA. STAT. § 409.902(1) (2025).

[76] UNIV. OF MINNESOTA, COLL. OF PUBLIC HEALTH, MEDICAID ELIGIBILITY, ENROLLMENT, AND RENEWAL PROCESSES AND SYSTEMS STUDY CASE STUDY SUMMARY REPORT-FLORIDA (Oct. 19, 2018), https://www.macpac.gov/wp-content/uploads/2018/11/Florida-Summary-Report.pdf.

[77] FLA. ADMIN. CODE R. 65A-1.205; 42 U.S.C. § 18083; 42 U.S.C. § 1396w–3; Florida Dep't. of Child. and Families, *Help Center*, MYACCESS https://myaccess.myflfamilies.com/Help/HCHCH (Scroll down to heading, "How to apply for benefits").

[78] 42 C.F.R. § 435.912(c)(3)(ii)); FLA. ADMIN. CODE R. 65A-1.205(1)(b).

ADVOCATE'S TIP

If at all possible, FHJP strongly advises applicants to apply online to DCF's MyACCESS website and to save their user ID and password.

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 the Social Security Administration and the Florida Department of Children and Families.[79]

DCF is required to process a disability related Medicaid application within 90 days.[80] 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.[81]

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.[82] 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.[83]

Individuals who are applying for Medicaid ***and*** Social Security Disability benefits need to apply through a Social Security Administration office or online. SSI recipients will automatically be routed to the Florida Department of Health Division of Disability Determinations (DDD), which also

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[79] *Help Center*, *supra* note 77 (Scroll down to heading, "How to apply for benefits").

[80] FLA. ADMIN. CODE R. 65A-1.205(1)(c)(4).

[81] FLA. ADMIN. CODE R. 65-2.066(5).

[82] *See* Pond v. Dep't of Health & Rehab. Servs., 503 So. 2d 1330, 1331 (Fla. 1st DCA 1987) (discussing 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).

[83] 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.").

reviews applications for Medicaid based on disability.[84] SSDI recipients whose income is too high for Medicaid will need to apply directly to DCF for "Medically Needy" enrollment.[85]
If DDD makes an adverse decision within 90 days (the time standard for Medicaid eligibility decisions based on disability),[86] the applicant can then begin the appeal process.[87]

If SSA has determined that the applicant is not disabled, that adverse decision precludes the applicant from pursuing an application for Medicaid based on disability with the state unless one of the following exceptions applies[88]:

(i) The applicant has a disabling condition different from or in addition to what was considered by SSA,

(ii) SSA made a determination more than 12 months ago, the disabling condition has changed or deteriorated, and the person has not reapplied to SSA for a redetermination, or

(iii) SSA made a determination less than 12 months ago, the disabling condition has changed or deteriorated, and:

1. The applicant applied to SSA for reconsideration or reopening of its denial, and SSA refused to consider the new allegations, or
2. The applicant no longer meets other SSI criteria, such as income or assets.

REDETERMINATIONS

Medicaid recipients are subject to a periodic review of their eligibility. Redetermination requires re-verification of certain eligibility factors.[89] 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.

For Medicaid beneficiaries whose financial eligibility is determined using the MAGI-based income rules, eligibility must be renewed once every 12 months and no more frequently than every 12 months.[90]

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[84] Fla. Dep't. of Health, Div. of Disability Determinations, *Disability Determinations*, FLA. HEALTH https://www.floridahealth.gov/programs-and-services/people-with-disabilities/disability-determinations/.

[85] Florida Dep't. of Child. and Families, *Medically Needy Program Information Flyer*, (Jul. 2015) https://drive.google.com/file/d/1u0xWjui4MUZtdLff_74akUDF2qFZJygR/view; *See also ESS Program Policy Manual*, *supra* note 2.

[86] FLA. ADMIN. CODE R. 65A-1.205(1)(c)(4).

[87] FLA. ADMIN. CODE R. 65A-2.042.

[88] 42 C.F.R. § 435.541(c)(2)-(4); *See also What If My DCF Notice Says My Medicaid is Ending but I am Disabled?*, FLA. HEALTH JUST. PROJECT (Oct. 2025) https://floridahealthjustice.org/publications/what-if-my-dcf-notice-says-my-medicaid-is-ending-but-i-am-disabled/.

[89] FLA. ADMIN. CODE R. 65A-1.704(1); 42 CFR § 435.916.

[90] *See* FLA. ADMIN. CODE R. 65A-1.704(1); 42 C.F.R. § 435.916(a)(1).

States are required to perform the renewal based on information that is already available, if possible.[91] If the state does not have the information needed to renew eligibility, it 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.[92] The preferred method for reporting changes is via the individual's online MyACCESS Account.

If the individual fails to provide the information needed for renewal, 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 to the effective date of closure.[93]

EX PARTE DETERMINATIONS

AHCA must continue to provide Medicaid to a beneficiary unless/until the DCF finds the individual 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.[94]

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; or
- An individual's SSI is cancelled.[95]

In 2019, a class action lawsuit was filed against the Florida agencies responsible for administering the state's Medicaid program. Plaintiffs, whose SSI or Adoption Assistance Agreement had been terminated, challenged the state's termination of their SSI or adoption-related Medicaid coverage without first examining their continued eligibility under *all* Medicaid categories and without

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[91] FLA. ADMIN. CODE R. 65A-1.704(2); 42 C.F.R. § 435.916(a)(2).

[92] *See* 42 C.F.R. § 435.916 (a)(3)(i) (discussing that states are required to send a "pre-populated renewal form").

[93] 42 C.F.R. § 435.916(a)(3)(iii); FLA. ADMIN. CODE R. 65A-1.704(2)(b)2.

[94] 42 C.F.R. §§ 435.930, .1003; FLA. ADMIN. CODE R. 65A-1.702(4); FLA. DEP'T OF CHILD. AND FAMILIES, PROGRAM POLICY MANUAL 800 ONGOING CASE PROCESSING 15 (2025), https://ffic.myflfamilies.com/manual/800.pdf (discussing § 0830.0600); Fla. Dep't. of Child. and Families, TRANSMITTAL No: P – 11-06-0007, Supplemental Security Income Termination Review Process, (June 7, 2011).

[95] *Id.*

providing proper notice of the action (the "*ex parte* review" requirement).[96] Pursuant to a settlement in 2020, the state implemented comprehensive corrective actions.[97]

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."[98]

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.[99]

A timely written notice is also required and must contain the following:[100]

- 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 appealing either eligibility or services.[101]

Eligibility appeals are conducted at the DCF Office of Appeal Hearings pursuant to Florida Administrative Code Rule 65-2.[102]

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

[97] *See* FLA. HEALTH JUST. PROJECT, HARRELL SETTLEMENT AGREEMENT (Feb. 13, 2020) https://floridahealthjustice.org/wp-content/uploads/2025/02/Harrell-Settlement-Agreement.pdf; *See also* Florida Dep't. of Child. and Families, TRANSMITTAL No: I – 20-12-0018 (discussing procedural changes implemented by DCF in response to the *Harrell* settlement agreement).

[98] *See* U.S. CONST. amends. V, XIV, § 1; Goldberg v. Kelly, 397 U.S. 254 (1970); *See also* 42 U.S.C. § 1396a(a)(3).

[99] *Id.*

[100] 42 C.F.R. § 431.210.

[101] FLA. ADMIN. CODE R. 65A-2.057(6).

[102] FLA. ADMIN. CODE R. 65-2. *See also* FLA. STAT. § 409.285(1); FLA. STAT. § 120.80(7), FLA. STAT. § 400.0255(8), FLA. STAT. § 393.125.

One important exception to the right to a hearing is if the only reason for the termination was a change in the federal law.[103] In such a case, no hearing is required.

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. The federal statute lists 29 categories of services that are covered under Medicaid as either optional or mandatory.[104]

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.[105]

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).[106]

For example, prior to 2024, the Florida Medicaid program covered the cost of incontinence supplies for medically incontinent children but discontinued coverage when the child turned 21. This was successfully challenged by two low-income adults in Florida with bladder and bowel incontinence.[107]

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; those 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.

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[103] 42. C.F.R. § 431.220(b).

[104] 42 U.S.C. § 1396d(a).

[105] 42 U.S.C. § 1396d(r)(5).

[106] *See* Smith v. Benson, 703 F. Supp. 2d 1262 (S.D. Fla. 2010) (challenging state Medicaid rule that excluded coverage of diapers without an exception for recipients under age 21).

[107] Meza v. Marstiller, No. 3:2022cv00783, 2023 WL 2648180, at *101 (M.D. Fla. 2023) (addressing the issue of whether medical incontinence supplies including diapers, must be covered for recipients who are 21 years or older; ACHA entered into a settlement agreement in which it agreed to continue with formal notice and comment rulemaking with the intention of extending coverage of medically necessary incontinence supplies for Medicaid State Plan recipients age 21 years and older).

FLORIDA MEDICAID SERVICES[108]

Mandatory Services

The federal statute § 1396a(a)(10) requires that certain services must be provided:

- 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[109]

Optional Services

The optional services Florida has chosen to cover currently include:

- Prescription drugs
- Adult dental services
- Adult health screenings
- Ambulatory surgical center services
- Case management services
- Birth center services
- Chiropractic services
- Community mental health services
- Dialysis facility services
- Durable medical equipment (DME)
- Healthy start services
- Hearing services
- Hospice care services
- Intermediate care facility for the developmentally disabled services
- Optometric services
- Physician Assistant services
- Podiatric services
- State Hospital services
- Assistive-Care services
- Anesthesiologist Assistant services

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[108] 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 their MCO. The services, both mandatory and optional, which are covered under Florida's managed care plan contracts are listed in the Statewide Medicaid Managed Care Model Contract, Attachment I, (Feb. 1, 2025), https://ahca.myflorida.com/content/download/26115/file/Attachment%20I%20-%20Scope%20of%20Services.pdf.

[109] 42 U.S. Code § 1396a(a)(10); FLA. STAT. § 409.905.

- Intermediate care services
- Visual services[110]
- Home and Community-Based Services ("HCBS") – through waiver only[111]

COST-SHARING

Minimal cost sharing is allowed under federal law, and the Florida Legislature has adopted cost sharing for certain services.[112]

However, there is currently an exemption disallowing cost-sharing for beneficiaries enrolled in a Medicaid managed care plan. Thus, cost sharing is not generally an issue in Florida because most Florida beneficiaries are enrolled in managed care.[113]

PROVIDER PARTICIPATION & BALANCE BILLING

Another major governing principle of Medicaid law 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.[114]

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.[115]

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-related Medicaid v. SSI-related Medicaid, or based on recipients' diagnoses. For example, if the state covers behavioral services but then excludes

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[110] FLA. STAT. § 409.906.

[111] *See, e.g.*, *The Advocate's Guide to the Long-Term Care Program*, FLA. HEALTH JUST. PROJECT (July 2022), https://floridahealthjustice.org/publications/advocates-guide-to-the-florida-long-term-care-medicaid-waiver/ (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).

[112] 42 U.S.C. §§ 1396a(a)(14), 1396o-1; FLA. STAT. § 409.9081; FLA. ADMIN. CODE R. 59G-1.056.

[113] FLA. STAT. § 409.9081(3)(f).

[114] 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).

[115] 42 U.S.C. § 1396a(a)(10)(B)(i); 42 C.F.R. §§ 440.230(c), 440.240(b)(1).

coverage of any behavioral services based on diagnosis, the "comparability" requirement will be violated.[116]

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 constituting "reasonable promptness" for services. Thus, disputes have arisen over what is "reasonably prompt" for different services.[117]

As discussed below, the Medicaid managed care regulations require access standards. This provides advocates and beneficiaries with some 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."[118]

There is no definition of medical necessity in federal law for adults. Rather, individual state Medicaid programs establish criteria for determining whether a particular health care service or supply is necessary for a beneficiary's diagnosis or treatment and therefore eligible for coverage. The applicable federal regulation simply provides that the service must be sufficient in "amount, duration, and scope" to achieve its purpose.[119]

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[116] 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) (entering a 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).

[117] *See* 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); *See also* Medina v. Planned Parenthood South Atlantic, 606 U.S. 357 ___ (2025).

[118] FLA. STAT. § 409.9131(2)(b).

[119] 42 C.F.R. § 440.230.

FLORIDA'S DEFINITION OF MEDICAL NECESSITY[120]

"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;
   a. Note, this requirement does not apply to recipients under 21.
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.

Individual states have significant flexibility in setting amount, duration, and scope standards. For example, Florida has limited coverage for adult inpatient hospital stays for a Medicaid recipient 21 years of age or older to 45 days per year.[121] This is a "reasonable" limit because it is sufficient in amount to cover the inpatient hospital needs of most beneficiaries.[122]

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.[123] Further, as indicated in the state's medical necessity definition highlighted above, the standard for children is less stringent.

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

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[120] *See* FLA. ADMIN. CODE R. 59G-1.010. *See also* FLA. AGENCY FOR HEALTH CARE ADMIN., DEFINITIONS POLICY 7 (May 20204), https://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf. (discussing § 2.83).

[121] FLA. STAT. § 409.905(5).

[122] *See* Alexander v. Choate, 469 U.S. 287 (1985) (holding that Tennessee could "reasonably" limit coverage of inpatient hospital days per year to 11); *See also* 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).

[123] *See* FLA. ADMIN CODE R. 59G-4.150; *See also* FLA. AGENCY FOR HEALTH CARE ADMIN., INPATIENT HOSPITAL SERVICES COVERAGE POLICY 2 (Mar. 6, 2025), https://ahca.myflorida.com/content/download/24381/file/59G-4.150%20Inpatient%20Hospital%20Services%20Coverage%20Policy.pdf (discussing § 2.2).

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.[124]

FOUR TYPES OF REQUIRED SCREENING SERVICES FOR 21 AND UNDER

1. Medical
2. Vision
3. Hearing
4. Dental

MEDICAL SCREENS

Screens, or well-child check-ups, are a basic element of the EPSDT program. The medical screen must include at least the following five components:

1. A comprehensive health and developmental history, including mental health
2. A comprehensive, unclothed physical exam
3. Immunizations
4. Laboratory testing when appropriate (at least at 12 and 24 months of age), including lead tests
5. Health education and anticipatory guidance[125]

Medical screens must be provided according to a "periodicity schedule."[126] Florida Medicaid follows the Bright Futures Recommendations for Preventive Pediatric Health Care.[127]

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[124] *The Right to Medically Necessary Treatment for Florida's Children,* FLA. HEALTH JUST. PROJECT (Mar. 30, 2021), https://www.floridahealthjustice.org/publications--media/the-right-to-medically-necessary-treatment-for-floridas-children.

[125] CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL CHAPTER 2- STATE ORGANIZATION, https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927 (discussing § 2700.4).

[126] 42 U.S.C. § 1396d (r)(5)(1).

[127] *Medicaid Well Child Visits (Child Health Check-Up Visits)*, FLA. AGENCY FOR HEALTH CARE ADMIN., https://ahca.myflorida.com/medicaid/child-health-services/medicaid-well-child-visits#:~:text=birth;,year%20for%20ages%203%2D20 (discussing the state's schedule for health checkups).

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 their own individual periodicity schedules. [128]

INTERPERIODIC ("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 "inter-periodic screens."

Persons outside the health care system (for example, a teacher or parent) can determine the need for an inter-periodic screen. Any encounter with a health care professional acting within the scope of practice is an inter-periodic screen, even if the provider is not participating in the Medicaid program at the time the screening services are furnished.[129]

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."[130] This includes all mandatory and optional services that the state can cover under Medicaid, regardless of whether such services are covered for adults.[131]

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[128] 42 U.S.C. § 1396d (r)(2)-(4); *Practice Management*, AM. ACAD. OF PEDIATRICS (June 20, 2025), https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx.

[129] K.G. *ex rel* Garrido v. Dudek, 839 F. Supp. 2d 1254, 1275 (S.D. Fla. 2013) (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.").

[130] 42 U.S.C. § 1396d (r)(5).

[131] *See* Smith v. Benson, 703. F. Supp 2d 1262, 1269 (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; the Court stated "every Circuit which has examined the scope of the EPSDT program has recognized that

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.[132]

Additionally, EPSDT requires state Medicaid agencies to "arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment.[133] This means that state Medicaid programs should not wait for claims to be submitted for EPSDT services, but rather affirmatively arrange for treatment, either directly or through appropriate referrals.

ADVOCATE'S TIP

Florida's definition of "medical necessity", which was the same for adults and children, was successfully challenged as overly restrictive for children in violation of EPSDT by a number of state District Courts of Appeal.[134]

INFORMING ELIGIBLE FAMILIES ABOUT EPSDT

States are required by federal law to inform all Medicaid-eligible persons in the state who are under 21 years old of the availability of EPSDT and immunizations.[135] States must use a combination of

states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a)").

[132] C.F. v. Dept. of Child. and Families, 934 So. 2d 1 (Fla. 3rd DCA 2006) (challenging successfully 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).

[133] 42 U.S.C. § 1396a(a)(43)(C).

[134] *See C.F.*, 934 So. 2d at 4 (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. Agency for Health Care Admin., 87 So. 3d 6 (Fla. 3rd DCA 2012); E.B. v. Agency for Health Care Admin., 94 So. 3d 708 (Fla.4th DCA 2012).

[135] *See* 42 U.S.C. § 1396a(a)(43)(A). *See also* 42 C.F.R. §§ 441.50, 441.55–.62 (The regulations pre-date the most recent statutory amendments and, to some extent, do not reflect the statutory changes); *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL CHAPTER 5- EARLY AND PERIODIC SCREENING, https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927 (discussing §§ 5010, 5121, 5150); DEP'T OF HEALTH AND HUM. SERVS., CTRS FOR MEDICARE & MEDICAID SERVS. BEST PRACTICES FOR ADHERING TO EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) REQUIREMENTS 3, 9-16 (Sept. 24, 2024) https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf. (explaining that states must assure the provision of necessary transportation, effectively inform eligible individuals about the EPSDT

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."[136]

SECTION FIVE: MANAGED CARE

BACKGROUND

Florida was one of the first states to mandate enrollment in managed care plans. In 2006, Florida received approval for a Section 1115 Waiver 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.[137]

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), Florida 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). [138]

On February 1, 2025, AHCA rolled out its updated Statewide Medicaid Managed Care program, or "SMMC 3.0." There is a significant amount of material on AHCA's website, including a homepage detailing the new "SMMC 3.0" program.[139] Under this new program, AHCA entered into new contracts with health and dental providers, and created a new plan structure. The SMMC program has three components: integrated managed medical assistance (MMA), Long-Term Care (LTC), and Dental Program.

Almost all Florida Medicaid recipients now receive their health care services through their MMA plan.[140] Broadly speaking, the goal of managed care is to ensure better health outcomes with lower

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benefit, and implement policies and practices that recognize the cultural beliefs and practices of the families and children they serve).

[136] 42 U.S.C. § 1396a(a)(43)(c); 42 C.F.R. § 441.62.

[137] 42 U.S.C. § 1315(a).

[138] *See* FLA. STAT. §§ 409.961-.9855.

[139] *Statewide Medicaid Managed Care*, FLA. AGENCY FOR HEALTH CARE ADMIN. https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care.

[140] *See* FLA. AGENCY FOR HEALTH CARE ADMIN., MANAGED MEDICAL ASSISTANCE PLAN VS FEE-FOR-SERVICE (Jan. 15, 2025), https://ahca.myflorida.com/content/download/25693/file/Managed%20Medical%20Assistance%20Plan%2

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.

ADVOCATE'S TIP

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 MMA plans and AHCA.

HOUSING ASSISTANCE PILOT PROGRAM

Housing Assistance:

In collaboration with certain health plans, AHCA implemented a housing assistance pilot program on December 1, 2019.[141] This program provides community support and services that assist in securing housing for Medicaid recipients ages 21 and older who are homeless or at risk of homelessness and have a serious mental illness (SMI), and/or substance use disorder (SUD).

Initially, this program was only available in Regions Five and Seven. In 2025, the MCO model contract provides plans with the option of including housing assistance and targeted case management services for certain eligible individuals.[142] All plans in Florida indicate that they are including this service for eligible individuals. [143]

0vs%20Fee-for-Service.pdf; *See also Medicaid Monthly Enrollment Report*, FLA. AGENCY FOR HEALTH CARE ADMIN., https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report ("The Agency publishes 16 Medicaid enrollment reports on a monthly basis." This includes MMA enrollment).

[141] *Housing Assistance Waiver Overview*, FLA. AGENCY FOR HEALTH CARE ADMIN., https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/housing-assistance-waiver.

[142] *See* AGENCY FOR HEALTHCARE ADMIN., 2025-2030 MODEL HEALTH PLAN CONTRACT ATTACHMENT I SCOPE OF SERVICES 13–23 (Oct. 2025), https://ahca.myflorida.com/content/download/27247/file/Attachment%20I%20-%20Scope%20of%20Services%20Oct%202025%20.pdf [hereinafter AHCA MODEL CONTRACT SCOPE OF SERVICES] (discussing § 1 Services to be Provided, allowing a plan option provision of: Housing Assistance and Targeted Case Management for people with homelessness or at risk for homelessness and diagnosis of SMI and/or SUD).

[143] *See* FLA. AGENCY FOR HEALTH CARE ADMIN., HEALTH PLAN EXPANDED BENEFITS GRID 2025 (Feb. 1, 2025) https://ahca.myflorida.com/content/download/25550/file/Health%20Plan%20Expanded%20Benefits%20Grid%202025%20-%2011-7-2024.xlsx.pdf; *See also* DEP'T. OF HEALTH AND HUM. SERVS., CTRS. FOR MEDICARE AND MEDICAID SERVS., FLORIDA MANAGED MEDICAL ASSISTANCE DEMONSTRATION (Jan. 31, 2025) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-mma-amend-appvl-01312025.pdf (Notably, while all plans have elected to cover this service, it is only available through those plans in regions A, B, C and E).

Developmental Disabilities Managed Care
AHCA has also launched the Intellectual and Developmental Disabilities (IDD) Pilot Program, commonly known as the Developmental Disabilities Managed Care Pilot Program.[144] On October 1, 2024, AHCA launched this program in Region Six and Region Eleven for people with IDD, who are on the Agency for Persons with Disabilities (APD) pre-enrollment list, to receive services through an integrated managed care delivery model.

ENROLLMENT POPULATIONS

The voluntary enrollment population for the Florida MMA program, as well as the population excluded from the entire SMMC managed care program, is listed below:

Who may (but need not) enroll in MMA?

- Recipients who have other creditable health care coverage, excluding Medicare
- Persons eligible for refugee assistance
- Residents of a developmental disability center
- Recipients enrolled in the iBudget waiver and those on the waitlist for the waiver
- Children receiving services in a prescribed pediatric extended care center
- Recipients residing in a group home facility licensed under Fla. Chapter 393[145]

Populations exempt from enrollment include:[146]

- 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 (EMA)

Most Medicaid recipients are required to receive their covered services through a managed care health plan.[147] They are referred to as "mandatory enrollees."

ENROLLMENT PROCESS

Medicaid recipients must enroll in the MMA program and in the Dental program. Individuals wishing to receive Medicaid-covered Long-Term Care services must enroll in the LTC program.

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[144] *Intellectual & Developmental Disabilities Comprehensive Managed Care (ICMC) Program*, FLA. AGENCY FOR HEALTH CARE ADMIN., https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/idd-pilot-program.

[145] FLA. AGENCY FOR HEALTH CARE ADMIN., A SNAPSHOT OF STATEWIDE MEDICAID MANAGED CARE 3.0, https://ahca.myflorida.com/content/download/25049/file/SMMC_Snapshot.pdf.

[146] FLA. STAT. § 409.965.

[147] AHCA MODEL CONTRACT SCOPE OF SERVICES, *supra* note 142, at 1 (discussing § 1 Services to be Provided).

Applicants for Medicaid are given an informed choice to select MMA plans or are auto-assigned into an MMA plan if they are mandatory for enrollment but do not choose a plan upon affirmation of eligibility. These enrollees have the opportunity to change a plan during a 120-day change period post-enrollment.[148] Voluntary enrollees can opt out and choose to stay in fee-for-service (FFS) at any time by contacting the Agency.

HOW TO CHOOSE A MANAGED MEDICAL ASSISTANCE PLAN

Choice counselors are available to assist recipients in selecting a plan that best meets their needs. This assistance will be provided by phone by calling 1-877-711-3662. In-person visits are also available by request for recipients with special needs.

Recipients can also enroll online at www.flmedicaidmanagedcare.com.

Recipients are encouraged to find a plan in which the individual's doctors are in-network in order to maintain continuity of care.[149]

MANAGED CARE SERVICES

What Services Must Be Covered?

At a minimum, all managed care plans must provide services that are enumerated in AHCA's Model Contract, Attachment I, Section I.[150]

In order to better understand what is and is not covered within any given service, AHCA's website includes a useful section titled "Adopted Rules – Service Specific Policies." The rule number and rule history for each covered service are provided, along with a PDF link to the coverage policies governing each service. [151]

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

[148] FLA. AGENCY FOR HEALTH CARE ADMIN., FLORIDA MANAGED MEDICAL ASSISTANCE WAIVER, SECTION 1115 RESEARCH AND DEMONSTRATION WAIVER, AMENDMENT REQUEST: STATEWIDE MEDICAID MANAGED CARE PLAN PROCUREMENT 24 (Oct. 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-mma-oct2024-amend-pa.pdf#:~:text=Voluntary%20enrollees%20will%20retain%20the%20right%20to,any%20time%20in%20accordance%20with%20STC%2025.

[149] A SNAPSHOT OF STATEWIDE MEDICAID MANAGED CARE 3.0, *supra* note 145.

[150] AHCA MODEL CONTRACT SCOPE OF SERVICES, *supra* note 142, at 1 (discussing § 1 Services to be Provided).

[151] *Adopted Rules–Service-Specific Policies*, FLA. AGENCY FOR HEALTH CARE ADMIN. https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies.

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 that are currently not covered by MMA health plans are available to eligible recipients through traditional fee-for-service Medicaid.[152] *e.g.,* Early Intervention Services (EIS), and Medical Foster Care.

What Access Standards Apply to the Health Plans?
The legislation implementing Florida's MMA program mandates that: "[t]he agency shall establish specific standards for the number, type, and regional distribution of providers 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."[153]

Additionally, an important goal of the federal Medicaid managed care regulations is ensuring that plans have sufficiently robust networks so that enrollees can access services in a timely manner. Accordingly, the Model Health Plan Contract sets forth "Network Adequacy Standards," which requires all health plans to "maintain a region-wide network of providers in sufficient numbers to meet the network capacity and geographic access standards for services with respect to the applicable SMMC program."[154]

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[152] *See* AGENCY FOR HEALTHCARE ADMIN., 2025-2030 MODEL HEALTH PLAN CONTRACT ATTACHMENT II EXHIBIT II-A–UPDATE: OCTOBER 1, 2025, MANAGED MEDICAL ASSISTANCE (MMA) PROGRAM 9 (Oct. 2025), https://ahca.myflorida.com/content/download/27249/file/Exhibit%20II-A%20Managed%20Medical%20Assistance%20%28MMA%29%20Program%20Oct%202025.pdf [hereinafter AHCA MODEL CONTRACT EXHIBIT II-A] (discussing § V Services administration, as of 2025, Applied Behavioral Analysis is a mandatory covered service under a Managed Care Plan).

[153] FLA. STAT. § 409.967(2)(c)(1).

[154] AHCA MODEL CONTRACT EXHIBIT II-A, *supra* note 152, at 65 (discussing § VII. Provider Network and Services).

APPOINTMENT ACCESS STANDARDS: [155]

Urgent Care: Appointment for urgent medical or behavioral health care services shall be provided within 48 hours if no prior authorization is needed, or within 96 hours if prior authorization is needed.

Non-Urgent Care: Appointments for non-urgent care services shall be provided:
- 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 STANDARDS:[156]

- **Primary Care**:
  Urban or Rural: within 20 miles/30 minutes
- **Specialists**: (depending on the specialist)
  Urban: 30-100 minutes/20-75 miles)
  Rural: 30-110 minutes/20-90 miles
- **Facilities/Hospitals**:
  Urban or Rural: within 30 minutes/20 miles
- **Behavioral Health**:
  Urban: 30 minutes/20 miles
  Rural: 60 minutes/45 miles

CHANGING PLANS & DISENROLLING

Changing Plans:
As mentioned above, applicants for Medicaid who are mandatory enrollees but do not choose a plan upon affirmation of eligibility are auto-assigned into a plan. These enrollees have the opportunity to change a plan during a 120-day change period post-enrollment.[157]

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[155] *Id.*

[156] *Id.* at 55.

[157] FLA. AGENCY FOR HEALTH CARE ADMIN., FLORIDA MANAGED MEDICAL ASSISTANCE WAIVER, SECTION 1115 RESEARCH AND DEMONSTRATION WAIVER, AMENDMENT REQUEST: STATEWIDE MEDICAID MANAGED CARE PLAN PROCUREMENT 24 (Oct. 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-mma-oct2024-amend-

After 120 days, recipients may only change plans for "good cause." Medicaid recipients enrolled in a managed care plan after the initial 120-day period shall remain in the plan for the remainder of the 12-month period. Once the 12-month period ends, recipients may change plans during the 60-day open enrollment period.[158] 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. Requests are made by phone to the choice counselor at 1-877-711-3662.[159]

Disenrollment:
Recipients may request disenrollment at any time via a written or oral request to AHCA.

Disenrollment is permitted as follows:

- Without cause, for voluntary enrollees, at any time[160]
- For good cause, at any time
- Without cause, for mandatory enrollees, within the first 120 days[161]

There are multiple authorities governing good cause for disenrollment.

Reasons for good cause disenrollment under Fla. Stat. § 409.969(2), include, but are not limited to:

1) Poor quality of care
1) Lack of access to services covered under the contract
2) Inordinate or inappropriate changes of PCPs
3) Service access impairments due to significant changes in the geographic location of services
4) An unreasonable delay or denial of service
5) Lack of access to providers experienced in dealing with the enrollee's health care needs
6) Fraudulent enrollment[162]

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pa.pdf#:~:text=Voluntary%20enrollees%20will%20retain%20the%20right%20to,any%20time%20in%20accordance%20with%20STC%2025.

[158] *Id.; see also Frequently Asked Questions*, FLA. AGENCY FOR HEALTH CARE ADMIN., https://www.flmedicaidmanagedcare.com/home/faq.

[159] *Enrolling in a Health Plan*, FLA. AGENCY FOR HEALTH CARE ADMIN. https://www.flmedicaidmanagedcare.com/health/enroll.

[160] *Id.*

[161] *See* FLA. ADMIN. CODE R. 59G-8.600; 42 C.F.R. § 438.56; FLA. STAT. § 409.969(2); *See also* FLORIDA MANAGED MEDICAL ASSISTANCE DEMONSTRATION, *supra* note 143 (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).

[162] FLA. STAT. § 409.969(2); AGENCY FOR HEALTHCARE ADMIN., 2025-2030 MODEL HEALTH PLAN CONTRACT ATTACHMENT II, CORE CONTRACT PROVISIONS 35 (Oct. 2025), https://ahca.myflorida.com/content/download/27248/file/Attachment%20II-%20-

Additional reasons under federal regulation and state rule include:

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[163]

FILING A COMPLAINT

Enrollees who are having trouble accessing services or who are encountering other problems with their managed care plan should 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. Individual complaints can often be resolved through this process.

A complaint may be filed either online (**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.[164]

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. There is an AHCA homepage for Florida Medicaid

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%20Core%20Contract%20Provisions%20Oct%202025.pdf [hereinafter AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS] (discussing § II Eligibility and Enrollment).

[163] *See* FLA. ADMIN. CODE R. 59G-8.600; *See also* 42 C.F.R. § 438.56.

[164] *Complaints*, FLA. AGENCY FOR HEALTH CARE ADMIN., https://www.flmedicaidmanagedcare.com/complaint#%2F%20.

Complaints where you can submit a complaint or check the status of your complaint.

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

Steps in filing an online complaint:[165]

- First, the **Basic Information** section asks the name of the complainant. The complainant must choose whether they are the Medicaid recipient, healthcare provider, or filing on behalf of the recipient or provider.
- Next, the complaint is requested to provide contact information.
- Next, under the **'Tell us about your issue'** section, the complainant is asked whether the affected person is a "Recipient, Provider, or General Population." This last section allows the complainant to describe in detail the issue and why a complaint is being filed.
    - At this time, there will be a series of drop-downs that must be completed. The complainant will be required to 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.
- Last, the complainant will be provided a **Complainant Number** and an **Issue Number**. It is important to keep a record of these numbers.

ADVOCATE'S TIP

While a beneficiary can file a complaint *pro se*, it is recommended that an advocate file the complaint on behalf of the beneficiary. The advocate also needs to file an Authorized Representative form to ensure that AHCA will speak to them. Florida Health Justice Project provides step-by-step instructions for filing a complaint regarding a Medicaid managed care plan, including a template to write a summary of the complaint.

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.[166] 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.[167]

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[165] *How to File a Complaint Regarding Reinstatement to My Managed Care Plan After My Medicaid Was Terminated In Error*, FLA. HEALTH JUST. PROJECT (Dec. 2024), https://floridahealthjustice.org/publications/how-to-file-a-complaint-regarding-reinstatement-to-my-managed-care-plan-after-my-medicaid-was-terminated-in-error/.

[166] 42 C.F.R. §§ 438.228, .56(d)(5); FLA. ADMIN. CODE R. 59G-8.600(3)(b).

[167] *See* 42 C.F.R. § 438.400(b) (defining "grievance"); *See also* FLA. ADMIN. CODE R. 59G-1.100(2)(b).

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
- 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[168]

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.[169]

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.[170]

Is there legal authority supporting the right to a fair hearing?
Under the federal Medicaid law, Medicaid beneficiaries have the right to a fair hearing if a claim for medical assistance is denied or not acted on with reasonable promptness.[171]

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.[172]

Are there any exceptions to the exhaustion requirement?

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[168] *See* 42 C.F.R. § 438.400(b) (defining "adverse benefit determination"); *See also* FLA. ADMIN. CODE R. 59G-1.100(2)(b).

[169] 42 C.F.R. § 438.400.

[170] 42 C.F.R. § 438.402(c)(2.; AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, supra note 162 at 78 (discussing § VI., D).

[171] 42 C.F.R. § 431.200; FLA. STAT. § 409.285; FLA. ADMIN. CODE R. 59G-1.100; AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 77 (discussing §VI).

[172] 42 C.F.R. § 438.402; FLA. ADMIN. CODE R. 59G-1.100 (3)(b)1; AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 83 (discussing § VI., J.).

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.[173]

What constitutes adequate notice?
The notice must include the following information:[174]

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 the enrollee may be required to pay

Additionally, the notice must be accessible to individuals with disabilities or limited English proficiency.[175]

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 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.
- **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.[176]

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[173] 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; AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 77 (discussing § VI.).

[174] 42 C.F.R. § 438.404(b); AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 79 (discussing § VI., E.).

[175] 42 C.F.R § 438.10.

[176] *See* 42 C.F.R. §§ 438.404, 431.211, 438.210.

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."[177]

Filing and handling a grievance or appeal with plan
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.)[178] The best practice is to file in writing with the plan.[179]

The plan must provide written notice acknowledging the receipt of the grievance or appeal within five business days.[180]

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.[181]

The MCO is the respondent, and "upon request by AHCA, the Agency may be granted party status by the Hearing Officer."[182]

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

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[177] 42 C.F.R. § 438.410; AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 82 (discussing § VI., H.).

[178] *See* AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 78 (discussing § VI., D.); *See also* 42 CFR §§ 438.402(c)(2)(i), (c)(3)(i).

[179] *See* AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 77 (discussing § VI); *See also* 42 C.F.R. § 438.406 (discussing provisions related to handling grievances and appeals).

[180] *See* AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 78 (discussing § VI., D.); *See also* 42 C.F.R. § 438.406 (b)(1).

[181] FLA. STAT. § 409.285(2).

[182] FLA. ADMIN. CODE R. 59G-1.100(4)(b).

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*.[183] 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.[184]

If the beneficiary is provided with continued coverage of the service and ultimately loses the appeal, the cost of the service can be recouped.[185]

What are enrollee rights in grievances and appeals?
Enrollees have the right to:

- Make legal and factual arguments in person and in writing;[186] and
- Present evidence, including new evidence not available at time of decision.[187]

Discovery and subpoenas
Florida 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."[188]

ADVOCATE TIP:

It cannot be overstated how helpful discovery can be 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

[183] 397 U.S. 254, 261 (1970).

[184] AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 77 (discussing § VI).

[185] *See id.*; *see also* 42 C.F.R. § 438.420(d).

[186] 42 C.F.R. § 438.406(b)(4); AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 77 (discussing § VI).

[187] 42 C.F.R. § 438.406(b)(5); AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 77 (discussing § VI).

[188] FLA. ADMIN. CODE R. 59G-1.100 (13)(a).

- Depositions

Advocates should also take advantage of the Model Contract's provision regarding review of the evidence packet, including any medical records or other documents/records considered or relied upon by the Managed Care Plan, **free of charge**.[189]

What are the time standards for filing and resolving grievances and appeals, and what notice is required?
Florida's filing and resolution time frames are as follows:

Type of Action	Filing Time Frame	Resolution Time Frame
Plan Appeal[190]	60 days from the date of the adverse benefit determination	30 days from the day the health plan receives the plan appeal
Expedited Appeal[191]	60 days from the date of the adverse benefit determination	48 hours after the health plan receives the expedited appeal
Grievance[192]	Can be filed at any time	30 days from the day the health plan receives the grievance
Fair Hearing[193]	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.[194]
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.[195]

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[189] AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 77 (discussing § VI).

[190] AHCA MODEL CONTRACT CORE CONTRACT PROVISIONS, *supra* note 162, at 80 (discussing § VI., F).

[191] *Id.* at 82 (discussing § VI., H.).

[192] *Id.* at 78 (discussing § VI., D.).

[193] *See id.* at 83 (discussing § VI., J.); *See also* FLA. ADMIN. CODE R. 59G-1.100(8).

[194] *Id.* at 82 (discussing § VI., G.).

[195] 42 C.F.R. § 438.408(e).

RELEVANT AUTHORITY

There are multiple authorities enumerated below that 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.

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 important regulations updates between 2016 and 2024.

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.[196]

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

- Attachment I re: Scope of Services, (February 1, 2025) https://ahca.myflorida.com/content/download/26115/file/Attachment%20I%20-%20Scope%20of%20Services.pdf
- Attachment II re: Core Contract Provisions, (February 1, 2025) https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf
- Attachment II, Exhibit II-A: Managed Medical Assistance Program, (February 1, 2025) https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.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. The waiver extension is effective until June 30, 2030. *See* https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81311.

[196] *See The Advocate's Guide to the Florida Long-Term Care Medicaid Waiver*, FLA. HEALTH JUST. PROJECT (July 2022), https://floridahealthjustice.org/publications/advocates-guide-to-the-florida-long-term-care-medicaid-waiver/.

Florida Administrative Rules
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 F.A.C. 59G-1.1.