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FLORIDA HEALTH JUSTICE PROJECT

Obtaining EPSDT Services

November 2025

Medicaid's Early & Periodic Screening, Diagnosis and Treatment Benefit – Federal Requirements

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Florida Health Justice Project Poverty Health Law Conference
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NATIONAL HEALTH LAW PROGRAM

About the National Health Law Program

- National non-profit law firm committed to improving health care access, equity, and quality for underserved individuals and families
- NHeLP's Litigation and Enforcement Work
- State & Local Partners:
  - Health Law Partnerships – 20+ states
  - Disability rights advocates – 50 states + DC
  - Poverty & legal aid advocates – 50 states + DC
- National Partners
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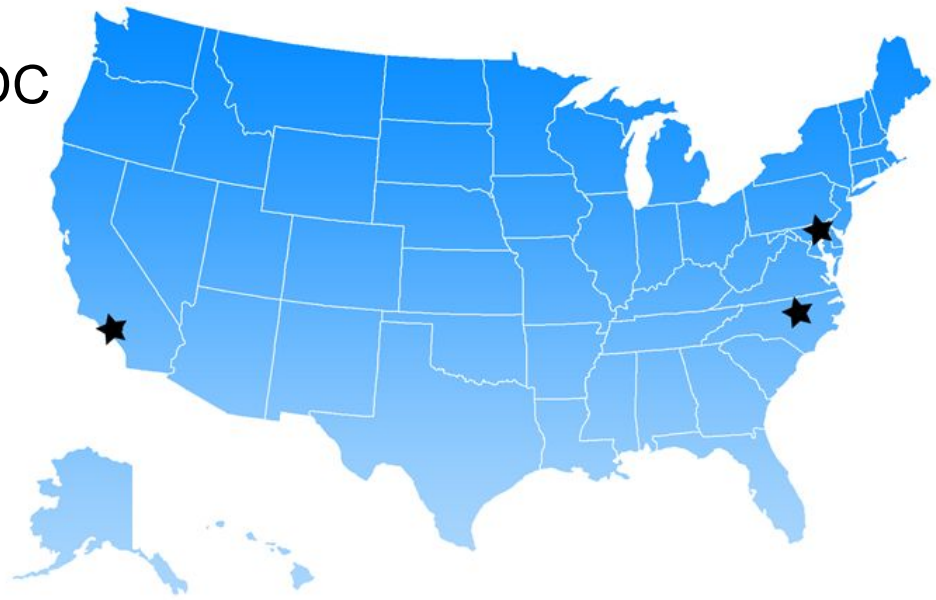

Goals for today

- Review Medicaid's federal EPSDT requirements
- Provide an overview of recent federal EPSDT guidance

Medicaid Early & Periodic Screening, Diagnostic & Treatment (EPSDT)

- Comprehensive approach to pediatric care for those under age 21
- Basic EPSDT Requirements:
  1. Early and Periodic Screening
     - Interperiodic screening
  2. Diagnostic & Treatment Services
     - Broad scope of benefits – all listed in 42 U.S.C. § 1396d(a)
     - Broader medical necessity scope
  3. Outreach
  4. Arrange for services the child needs
  5. Reporting

"The right care to the right child at the right time in the right setting."

Key Mandatory Services

- Physician Services
- Laboratory/x-ray
- Inpatient, outpatient hospital
- Nursing facility
- Family planning
- Nurse midwife services
- Certified nurse practitioner services
- Home health
- FQHCs & RHCs
- EPSDT

Optional Services

- Prescription drugs
- Prosthetic devices
- Medical care recognized under state law (e.g., podiatry, optometry)
- Dental
- Rehabilitative services
- Case management
- Certain institutional services
- Private duty nursing, personal care services and other HCBS
- Other services approved by the Secretary of HHS

EPSDT Treatment Requirement

All necessary treatment listed in § 1396d(a)

- To "*correct or ameliorate* physical and mental illnesses and conditions," even if the service is not covered under t he state plan

No mandatory/optional distinction

SHO #24-005 – CMS, Best Practices for Adhering to EPSDT Requirements (Sept. 26, 2024)

- Required by Bipartisan Safer Communities Act (2022)
- Purpose: Provide states information needed to comply with EPSDT
- Organization of the SHO
  - Overview of EPSDT requirements
  - Strategies for compliance
  - Best practices to maximize use of EPSDT

SHO #24-005 – Topics Covered

- Promoting EPSDT awareness & accessibility
- Expanding & using a child-focused workforce
- Improving care for children with special needs

Highlights of the SHO

- EPSDT is individualized; therefore, individual children must get the care they need, when they need it, in the most appropriate setting
- Regardless of the use of contractors (e.g., MCPs), states retain ultimate responsibility for ensuring compliance with EPSDT requirements
  - EPSDT coverage requirements apply to the state and MCPs
- Emphasizes that states must cover services needed to “correct or ameliorate” the child’s condition

Who is eligible for EPSDT in Florida?

Children in low-income families
Children in home & community-based waivers
Children on SSI
Children in Foster Care
Foster Youth & Young Adults

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Who administers EPSDT services in Florida?

Agency for Health Care Administration (AHCA)

- Florida's single state Medicaid agency — oversees the entire Medicaid program.
- Handles EPSDT implementation, enforcement, and appeals through the Office of Fair Hearings.

Managed Care Organizations (MCOs)

- AHCA contracts with private MCOs to deliver EPSDT-covered services.
- MCOs make initial coverage and prior-authorization decisions subject to AHCA oversight.

Florida's Definition of Medical Necessity

- Protect life, prevent significant illness or disability, or alleviate severe pain
  - *This threshold applies only to recipients age 21 and older.*
- Be individualized, specific, and consistent with the symptoms or confirmed diagnosis—not excessive for the patient's needs
- Meet generally accepted professional medical standards and not be experimental or investigational
- Reflect the safest, most effective, and least costly treatment available statewide
- Not be furnished primarily for convenience of the recipient, caretaker, or provider

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Medical Necessity (Federal vs. Florida)

Federal	Florida
“Correct or ameliorate” illness or condition	“Prevent significant illness or disability” (pre-WB)
Preventive & developmental	Crisis-based
Applies only to children	Applied to children & adults identically
No “convenience” clause	Explicitly excludes services deemed for convenience

Evolution of Florida's Medical Necessity Standard

C.F. v. DCF (Fla. 3d DCA 2005)

- Court held Florida's restrictive "medical necessity" rule violated federal EPSDT law.
- Required coverage for services that correct or ameliorate a child's condition, not just those preventing *significant illness or severe pain.*

Q.H. v. Sunshine State Health Plan (Fla. 4th DCA 2020)

- Reaffirmed *C.F.* and labeled Florida's standard "overly restrictive."
- Clarified that states cannot use preset criteria or narrow checklists to deny EPSDT services.

W.B. v. AHCA (M.D. Fla. 2023)

- Class action challenged AHCA's continued use of the adult "significant illness/severe pain" test for children.
- Settlement required rule amendment (2024) limiting that threshold to adults (21+).

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Why this matters...

- Denials for “insignificant” illness or “non-severe” pain violate EPSDT.
- Managed Care Organizations often replicate AHCA’s restrictive policy.
- Beneficiaries (and advocates) must insist on the federal standard: “necessary to correct or ameliorate” — not “to prevent significant illness.”

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Florida's EPSDT (Dental)

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Federal EPSDT Language (1396d(r)(3))

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health

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“Recent” EPSDT Dental Case Law

- *Chappell v. Bradley*, 834 F. Supp. 1030 (N.D. Ill. 1993) – Compliance requires individualized review of dental need, not categorical denials.
- *Jacobus v. Dep’t of PATH*, 857 A.2d 785 (Vt. 2004) – Required coverage of “interceptive” orthodontic treatment; agency’s narrow rule invalid.
- *Semerzakis v. Comm’r of Soc. Servs.*, 873 A.2d 911 (Conn. 2005) – Clarified dental benefits governed by § 1396d(r)(3).
- *Barajas v. Coye*, No. CIV-S-92 (E.D. Cal. 1992) – Consent decree mandated dental sealant program.

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Key Sources for EPSDT Dental Advocacy in Florida

- **AHCA Dental Contract (2018–2024)**
  Florida's statewide managed dental plan contract outlining plan duties, coverage, and network obligations.
  https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/2018-2024-model-dental-plan-contract
- **Florida Medicaid Dental Coverage Rule (59G-4.060, F.A.C.)**
  Governs dental benefits, limitations, and medical-necessity criteria under Florida Medicaid.
  https://ahca.myflorida.com/content/download/5945/file/59G-4.060_Dental_Coverage_Policy.pdf
- **NHeLP Memo on Medicaid Coverage of Orthodontia (2005)**
  Summarizes national EPSDT dental cases (*Mitchell*, *Chappell*, *Jacobus*, *Salazar*, etc.).
  Notes that "bright-line tests to determine eligibility violate Medicaid mandates" and stresses individualized review of medical necessity.

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How to Handle a EPSDT Dental Case

- Identify the services needed and “fit” the services into one of Medicaid’s covered services under federal law;
- Make sure a treating professional has recently prescribed the needed service and obtain copies of this documentation;
- Identify a health care professional, preferably the treating physician, who can substantiate the need for the services through a letter and ideally through testimony if a hearing is necessary;
- Write the AHCA area office and the managed care plan (if the child is enrolled in one) requesting the services. If the child is in the Waiver program, ask the waiver support coordinator to make this request to the AHCA area office as well.

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9-Year-Old v. Liberty Dental

- **Clinical need:** child was experiencing severe headaches due to impacted tooth that requires braces
- **Initial denial:** Liberty Dental cited “handicapping malocclusion” score (needed 24; scored 12–13) and checked the adult “protect life/prevent significant illness” box on the NABD.

9-Year-Old v. Liberty Dental

- **Our actions (FHJP):**
  - Opened case immediately; served discovery, requested the plan file, and collected records.
  - Secured medical-necessity letters (oral surgeon; pursued orthodontist/PCP support).
  - Coordinated closely with mom; confirmed hearing date; sought continuance as needed.
  - Engaged plan case manager/GC; transmitted complete clinical packet and legal memo.

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9-Year-Old v. Liberty Dental

Legal Hooks:

- EPSDT dental mandate — 42 U.S.C. § 1396d(r)(3) (relief of pain, restoration, maintenance), plus ameliorative standard.
- No bright-line scoring; must do individualized review (e.g., *Chappell*, *Jacobus*).
- Post-W.B.: adult “protect life / significant illness” threshold does not apply to <21.

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9-Year-Old v. Liberty Dental

Practice takeaways:

- Front-load a persuasive, clinician-signed medical-necessity letter tied to EPSDT.
- Attack score-only denials; demand individualized assessment.
- Work several lanes: legal (discovery/appeal) + operational (case manager/GC) + storytelling (if need be)

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EPSDT AND PRIVATE DUTY NURSING

PRIVATE DUTY NURSING

- If medically necessary under EPSDT, Medicaid is required to provide appropriate private duty nursing hours
- 59G-4.261 Florida Administrative Code-Part of Fla. Admin. Code related to PDN
- 59G-4.261 is also the section of AHCA Policies dealing with PDN and HHA Services
- 59G-1.100-Part of Fla. Admin. Code controlling AHCA Fair Hearings

PDN CRITERIA

- Medically Necessary
- Does not duplicate another service
- Recipient meets the following criteria:
  - Under the care of a physician and has an order for PDN
  - Requires more extensive and continual care than can be provided through a home health visit
  - Service can be safely provided in the home or community

Denial or Reduction of PDN

The reason for our decision was : The previous decision regarding private duty nursing services is upheld based on a lack of medical necessity. The clinical information that we received does not indicate that your child is dependent on a tracheostomy and/or invasive ventilator. Your child does not need multiple medications administered in the veins. They do not need continuous tube feedings. The previously approved hours should be adequate to provide care overnights. Criteria: Review of Private Duty Nursing Requests, POLICY ID: FL.UM.26.00. This decision was made with regards to EPSDT.

EPSDT

- Why are PDN hours necessary?
- Why requesting this number of hours?
- Letter of Medical Necessity
- M.H. v. Commissioner of Georgia Department of Community Health *11 F.4th 1301 (11th. Cir., 2024)-reducing minor patient's skilled nursing hours after parents learned to perform skilled tasks complied with Medicaid Act*

LETTER OF MEDICAL NECESSITY

- Should be coming from medical provider(s)
- Is essential in all PDN cases
- Don’t hesitate to get LMN from more than one medical provider

INTERNAL APPEAL TIPS

- Get letter of Medical Necessity
- Get a letter from parent(s) doctor if appropriate
- Letter from parent(s) telling their story
- PDN Plan of Care/Nursing Notes
- Draft a letter incorporating main points
- TELL STORY ABOUT PATIENT AND WHY PDN IS MEDICALLY NECESSARY USING EPSDT

APPEAL STEPS

Request for PDN is denied or hours reduced

Read entire denial

Request Medical Provider peer to peer with medical director at insurance company

Medical provider has 48 hours to request the peer to peer from the date of the denial/reduction

APPEAL STEPS CONT'D

Request internal appeal

Have 60 days to request internal appeal from date of denial letter	If hours are being reduced, have 10 days to request hours continue while appeal is ongoing

Request an AHCA Fair Hearing

Have 120 days to request the fair hearing from the date of the denial of the internal appeal	If hours are being reduced have 10 days to request hours continue while appeal is ongoing

Advocating for Children's Medicaid Behavioral Analysis Services

Leigh Markowitz
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Community and Healthcare Services

November 2025

Disability Rights Florida

- Funding, responsibility, and authority under nine federal programs to protect the rights of Floridians with disabilities.
- A not-for-profit corporation since 1987.
- Offices in Tallahassee, Tampa, Gainesville and Fort Lauderdale.
- Satellite offices in several other communities.

Our Mission

- Disability Rights Florida advocates, educates, investigates, and litigates to protect and advance the rights, dignity, equal opportunities, self-determination, and choices for all people with disabilities.

Agenda

- Behavioral Analysis Services
- Trends in Denials/Reductions/Terminations
- Appealing your Denial/Reduction/Termination
- Questions

What are Behavior Analysis Services?

- Behavior analysis services are provided to assist recipients to learn new, or increase existing, functionally equivalent replacement skills directly related to existing **challenging behaviors**.
- Challenging behaviors include those behaviors exhibited by the recipient that pose risk of harm to the recipient or others
  - Examples: aggression, self-injury, property destruction
  - Behaviors that prevent inclusion in typical settings
  - Behaviors that the recipient does not exhibit with sufficient proficiency or skill that may harm the recipient or others, including resisting basic hygiene, and refusal to take medications

Behavior Analysis Services Basics

- The enrollee's behavior is assessed to identify functional relationships between a particular behavior and the recipient's environment. A variety of techniques, including positive reinforcement, are used in order to produce practical behavior change.
- Behavior analysis services should be initiated with a plan for maintaining and generalizing behavioral improvements, as well as an initial criteria for the reduction and fading of behavioral services. The plan should also set forth target behavior criteria to be achieved by the recipient that lead to a specified reduction in the level of service.
- Subsequent to the initial plan, an updated fading plan must be addressed, at a minimum, as part of the annual report.

Current Trends:
Reasons for Denial/Reduction/Termination

- The request for a BA assessment does not contain all the necessary information
  - For example: the professional recommending BA services does not include a description of the maladaptive behaviors and how they impact the recipient daily
- The Behavior Plan contains elements that are not standard practices within the field of BA
  - For example: cool down or meditation techniques
- The behavioral data does not match the progress notes
  - For example: data shows an increase in behaviors, but the notes indicate the recipient is making progress in reducing behaviors

Current Trends:
Reasons for Denial/Reduction/Termination

- The level of services are not clearly defined in the Behavior Plan
  - For example: A requested increase in services is not clearly supported by data and recommendations in the Behavior Plan
- Showing improvements/not showing improvement at current level
  - Example: The individual is showing improvements at the current level of services, so the health plan reduces services under the assumption that they are no longer needed at the same level.
  - Example: The individual is not showing improvements at the current level of services, but the behavior plan is not changing.

Tips for Behavior Plan Approval

- Description of maladaptive behaviors should be clear, concise, observable and measurable
- Update data/graph time frame to one-year authorization period (for continuation of service requests) to clearly document individual's progress with Behavior Analysis Services
- Goals should be clearly tied to maladaptive behaviors
- Plan should conform with standards of care within the field of Applied Behavioral Analysis (ABA)
- All requests for Behavior Analysis Services should be based only on medical necessity to treat maladaptive behaviors

Appealing your Denial/Reduction/Termination

- The Notice
- The Internal Appeal
- The Office of Fair Hearings
- The Burden
- Medical Necessity
- Due Process Considerations
- Witnesses
- Discovery
- Negotiating Settlement

Advocacy 101

- Disability Rights Florida's Advocacy 101 is a manual designed to assist individuals in preparing for a Medicaid case before:
  - Florida Division of Administrative Hearings (DOAH)
  - **The Florida Office of Fair Hearings (OFH - Agency for Health Care Administration)**
  - The Florida Office of Appeal Hearings (OAH - Department of Children and Families)
- Available online: https://www.disabilityrightsflorida.org/resources/disability_topics/category/healthcare_and_medicaid

Questions?

Please contact Disability Rights Florida at:

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