

THE ADVOCATE'S GUIDE TO THE FLORIDA MEDICAID PROGRAM

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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 asked by advocates, applicants and beneficiaries including:

- who is eligible for Medicaid;
- how to apply;
- what to do if an application is denied or delayed;
- what to do if eligibility is terminated;
- what services are covered;
- how does managed care work;
- what to do if services are denied, delayed, terminated or reduced?¹

HISTORY

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

Half a century later, the Affordable Care Act eliminated this requirement of a

"categorical connection." The overarching goal of the ACA was to establish a path to affordable 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,² it also required states to expand their Medicaid program to provide coverage for low-income adults under 138% of FPL.³

Shortly after passage of the ACA, Florida and other states sued the federal government alleging, *inter alia*, that this "Medicaid expansion" was unconstitutional. In *National Federation of Independent Business v. Sebelius* (NFIB), the Court upheld the ACA's individual mandate as constitutional. The Court also ruled, however, that requiring states to expand their Medicaid programs to cover low income adults who did not meet a categorical connection was "overly coercive."⁴ The Court's decision meant that each state would decide whether or not to extend coverage to this group. As of April 2018, Florida is one of 19 states that has refused federal funding for coverage of the Medicaid expansion population.

SOURCES OF FEDERAL AND STATE AUTHORITY

Federal Law:

42 U.S.C. §§ 1396 – 1396w-5

42 C.F.R. §§ 430 – 456-725

Federal Policy:

Centers for Medicare and Medicaid Services (CMS)

State Medicaid Manual
Dear State Medicaid Director Letters
Regional Letters from CMS
(www.cms.gov, www.medicaid.gov)
State Law:
Florida Statute §409.901-409.9531
Florida Administrative Code 59G
Florida Administrative Code 65A-1
State Policy:
Florida Dept. of Children and Families
Program Policy Manual⁵

MEDICAID ADMINISTRATION AND FUNDING

At the federal level, Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (USDHHS). CMS divides the states into ten different regions, with a regional office for each, and Florida is in Region IV.⁶

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).

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

eligible enrollees, the federal government provides approximately \$.62⁷

Had Florida expanded Medicaid under the ACA, the federal government would have paid 100% for the first three years after the ACA was implemented (2014-17). If/when Florida chooses to extend coverage to those low income adults eligible for Medicaid under the ACA, the federal matching rate for the cost of covering this population will be no less than 90% as of 2020 and thereafter.⁸

SECTION TWO: ELIGIBILITY, APPLICATIONS AND APPEALS

ELIGIBILITY OVERVIEW

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

Eligibility requirements include financial (income and resources) as well as technical requirements, e.g. citizenship and residency. Different financial eligibility limits and methodologies apply depending on whether the individual's categorical connection to Medicaid is disability or family Related.

Eligible individuals who qualify for coverage under any mandatory or optional category are known as the "categorically needy."⁹ 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."¹⁰

Florida's mandatory and optional coverage groups are set forth below.

<u>MANDATORY COVERAGE GROUPS¹¹</u>
Low-income parents & caretakers
Pregnant women
Children 0-19
SSI recipients
Low income aged, blind and disabled not on SSI e.g. Protected Medicaid & "Pickle People" ¹²
Medicare-related programs
Youth to age 26 aging out of foster care
Emergency Medicaid for aliens (EMA) ¹³
<u>OPTIONAL COVERAGE GROUPS¹⁴</u>
Women with breast or cervical cancer
Medically needy
State adoption assistance
HCBS Waivers
Elderly/PWDs
Developmental Disabilities
Meds-AD ¹⁵
HIV needing hospital level of care ¹⁶

FAMILY RELATED MEDICAID ELIGIBILITY

Florida's Family Related Medicaid Groups include the following:

- Infants 0-1
- Children 1-5
- Children 6-18
- Children 19-21
- Pregnant Women
- Parents/Caretakers of minor children

CONTINUOUS ELIGIBILITY FOR CHILDREN

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

Pursuant to this option, Florida covers children up to age 19 for 6 months and children up to age 5 for 12 months, "regardless of changes in circumstances."¹⁷

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).¹⁸ The National Health Law Program has provided a comprehensive guide to understanding MAGI.¹⁹

Generally, MAGI includes the adjusted gross income plus certain exclusions such as any tax-exempt Social Security, interest and foreign income.²⁰

MAGI does include:²¹

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

MAGI does not include:²²

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

- Inheritance
- Tax Credits/Refunds

For the purposes of calculating MAGI for Medicaid, lump sum payments are counted only for the month they are received. In addition, scholarships, awards, and fellowship grants are not included as income unless they are used for living expenses rather than for education.²³

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.^{24, 25}

SSI RELATED MEDICAID ELIGIBILITY

Florida's SSI related Medicaid coverage groups include the following:²⁶

- 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).

To meet eligibility requirements for SSI Medicaid, individuals must have resources below \$2,000 for an individual

and \$3,000 for a couple.²⁷ There are exceptions for some of the other SSI-related programs.²⁸ For example, in order to qualify for the Medicaid for the Aged, an individual must not have resources exceeding the current Medically Needy resource limit of \$5,000.²⁹ Resources are defined as assets that a person owns and has authority or power to convert to cash or make available for her support.³⁰

Not all resources are counted towards the limit. For example, the principal place of residence, personal effects, household goods, necessary motor vehicles and limited cash value of life insurances are excluded.³¹

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,³² and trust funds.³³ If an individual can prove that something, which ordinarily is counted, is unavailable, it should not be counted.³⁴

CITIZENSHIP REQUIREMENTS.

To be eligible for Medicaid coverage an individual must be a U.S. citizen or a "qualified alien."³⁵ Certain qualified aliens are prohibited from receiving Medicaid for the first five years after they immigrate.³⁶ There is no coverage for unqualified immigrants except through Emergency Medical Assistance to Aliens (EMA).³⁷

Qualified aliens not subject to five-year wait include: refugees; asylees; individuals who are veterans or on active duty military; spouses and children of veterans or active military personnel; American Indians born in Canada Cuban or Haitian entrants; Amerasian immigrants trafficking victims; and lawful permanent residents admitted before August 22, 1996 and residing continually in the U.S. since admission.³⁸

Qualified aliens subject to five-year wait period include: adult lawful permanent residents admitted after August 22, 1996 (ineligible from the date of entry or obtaining qualified status, whichever is later); parolees; conditional entrants; and battered aliens.³⁹

Significantly, in 2016 Florida eliminated the 5-year bar through the Immigrant Children's Health Improvement Act (ICHIA) option for children for Medicaid and CHIP (Florida KidCare).⁴⁰

STATE RESIDENCE

Medicaid eligibility is dependent on state residency.⁴¹ An individual is a resident of Florida if she resides 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. However, the requirement will not be satisfied if the stay is for a temporary purpose or there is intent to return to another state.⁴²

If the individual is living in the State for employment purposes without the intent to remain, she/ he meets 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.⁴³

In October 2017, DCF issued a policy transmittal regarding the residency requirements for evacuees from Puerto Rico due to Hurricane Maria.⁴⁴

OTHER ELIGIBILITY REQUIREMENTS

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

- Have a Social Security number or have applied for one;⁴⁵
- provide verification of all health insurance;
- assign to the state all rights to payment for health care from any third parties;
- cooperate with the local child support enforcement agency in establishing paternity and securing medical and child support for any deprived child for whom the individual is caretaker when assistance is requested for the child;⁴⁶
- apply for all other benefits to which they are entitled; and not be residing in a penal institution.⁴⁷

RETROACTIVE MEDICAID

Under federal Medicaid law, costs incurred during the three months prior to the month of application can be reimbursed if: 1) they are covered under the Florida Medicaid plan; and 2) the beneficiary would have been eligible for Medicaid at the time the expenses are incurred.⁴⁸

The 2018 Legislature, however directed AHCA to seek federal approval to change this provision for non-pregnant adults. For those individuals, costs would only be covered from the first day of the month of application.⁴⁹

The initial state comment period ended April 19, 2018, see http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_amend_waiver_LIP_2018-03.shtml. This Guide will be updated following the full comment period and a decision by CMS.

SECTION THREE: APPLICATIONS AND DETERMINATIONS

If a person fulfills the state's requirements for eligibility, she/he is entitled to Medicaid. States may not place limits on enrollment or place applicants on waiting lists (except for home and community based waivers). In other words, Medicaid is an entitlement.⁵⁰

In Florida, the Department of Children and Families determines eligibility,⁵¹ and

there should be "no wrong door" for applicants.

APPLYING FOR FAMILY-RELATED MEDICAID

Because there is "no wrong door," applications can be made in person with a DCF community partner, at a DCF community service center, by paper application through the mail or by fax, online at the DCF ACCESS Florida website, <http://www.myflorida.com/accessflorida>, or online at the Health Insurance Marketplace website, www.healthcare.gov⁵² As a practical matter, applying online to DCF's ACCESS website above is generally recommended as the quickest method. DCF has 45 days to process the application and issue an eligibility determination.⁵³

APPLYING FOR DISABILITY-RELATED MEDICAID

There is also "no wrong door" for Medicaid applications based on disability.⁵⁴ The DCF is required to process the application within 90 days.⁵⁵ If the application is denied, there is an appeal right before an independent DCF hearing officer. The DCF hearing officer is required to issue a decision within 90 days of request.⁵⁶

In spite of 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.⁵⁷ Additionally, if the determination is delayed without appropriate explanation or excuse,

the recipient is entitled to full reimbursement for out-of-pocket expenses incurred while attempting to apply.⁵⁸

Individuals who are applying for Medicaid **and** Social Security Disability benefits, need to apply through a Social Security Administration office or the SSA website. SSI recipients will automatically be routed to the Division of Disability Determinations (DDS), which reviews applications for Medicaid.⁵⁹ SSDI recipients whose income is too high for Medicaid will need to apply directly to DCF for Medically Needy.

If DDS makes an adverse decision within 90 days (the time standard for Medicaid eligibility decisions based on disability),⁶⁰ the applicant can then begin the appeal process.⁶¹

Additionally, if the SSA determines that the applicant is not disabled, DCF can make an independent determination. However, the adverse decision will likely prevent the applicant from being found eligible for Medicaid with DCF with very limited exceptions.⁶²

ADVOCATE TIPS

Applicants for family related Medicaid, should apply online with DCF, rather than through the health care marketplace.

Applicants who are disabled, appear financially eligible for disability related Medicaid and are not seeking cash assistance, should apply with DCF for Medicaid based on disability rather than applying for SSI/Medicaid at the Social Security Administration.⁶³

REDETERMINATIONS

Medicaid recipients are subject to a periodic review of their eligibility. Redetermination requires re-verification of certain eligibility factors.⁶⁴

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

Under the ACA, this process was changed for Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income rule to provide that eligibility be renewed once every 12 months and no more frequently than every 12 months.⁶⁵

Given the improved databases available post ACA, DCF is better able to perform the renewal abased on information that is already available and can often DCF make redeterminations of eligibility without requiring additional information from the beneficiary.

If DCF does not have the information needed in order to renew eligibility, they will be send a notice to the individual giving at least 30 days to provide the necessary information. The preferred method for reporting changes is via the individual's on-line My ACCESS Account. Individuals can report changes over the phone at the DCF statewide call

center ([866-762-2237](#)), by mail or in person.

If the individual is eligible, DCF sends a Notice of Case Action notifying the individual (or assistance group) of continued eligibility and informing the individuals to access their only account with ACCESS to review the information used in that determination. If the information is not current, the individual(s) is instructed to report the change.⁶⁶

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. This policy is referred to as "Gap Coverage for Medicaid Renewals" and applies to individuals with either MAGI (family-related) eligibility or SSI-related eligibility.⁶⁷

EX PARTE DETERMINATIONS

Under Medicaid law, AHCA must continue to provide Medicaid to beneficiary's unless/until the individual is found to be ineligible. In other words, DCF must on its own (or "ex parte") determine whether a Medicaid beneficiary who is no longer eligible under one coverage group is eligible under a different coverage group, and coverage must be continued during this process.⁶⁸

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

- An increase in income or assets causes ineligibility;
- An individual's SSI is and cancelled.

NOTICE AND HEARING RIGHTS

Pursuant to the federal Medicaid statute and the Due Process clause of the U.S. Constitution, applicants and recipients have a right to both a notice and a hearing when a claim for assistance is denied or not acted on with "reasonable promptness."⁶⁹

Individuals are entitled to notice and an opportunity for a hearing when the state makes an adverse action including: decisions denying, terminating or modifying assistance; or failing to take an action within a reasonable time.⁷⁰

A timely written notice is also required and must contain:⁷¹

- A statement of the intended action;
- Reasons for the action;
- Citation to the law supporting the action
- An explanation of the right to hearing'
- An explanation of the right to continued assistance in cases involving termination or suspension
- A statement of the right to be represented.

Florida provides the right to discovery in administrative hearings both with regard to eligibility and services.⁷²

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

One important exception to the right to a hearing is if the only reason for the termination was change in the federal law.⁷³

SECTION FOUR: SERVICES

OVERVIEW

In determining if a particular service is covered, it must be either a mandatory service or an optional service that Florida has elected to cover. As discussed more fully below, for recipients under age 21, services that are either optional or mandatory must be covered if necessary to “correct or ameliorate” a condition or illness.⁷⁴

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

The federal statute lists 29 “categories” that generally describe the services that are covered under Medicaid--both optional and mandatory.⁷⁵

Litigation has arisen when there is a difference of opinion between the state Medicaid agency and beneficiary(ies) over whether a specific service or item

fits under one of those “buckets” in 1396d(a).

For example, *Smith v. Benson* addressed the issue of whether medical incontinence supplies, e.g. diapers, must be covered for recipients under age 21 when prescribed for incontinence-based or a medical condition. The state Medicaid agency argued that diapers and other incontinence supplies did not fit under any of the enumerated categories of coverage in section 1396d(a). Plaintiffs prevailed by establishing that diapers are included within the home health service coverage category.⁷⁶

FLORIDA MEDICAID SERVICES⁷⁷

MANDATORY SERVICES⁷⁸

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

OPTIONAL SERVICES⁷⁹

The optional services Florida has chosen to cover currently include:

- Prescription drugs
- Adult Dental
- Adult preventative health screenings
- Ambulatory Surgical Center Services
- Case Management services
- Birth Center
- Chiropractic services
- Community Mental Health Services
- Dialysis
- DME
- Healthy Start
- Hearing services
- HCBS – thru waiver only
- Hospice
- ICF/DD
- Optometric
- Physician Assistant
- Podiatry
- State Hospital
- Assistive Care
- Anesthesiologist Assistant

GENERAL PRINCIPLES OF MEDICAID SERVICES

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

COST-SHARING

Minimal cost sharing is allowed under federal law and the Florida Legislature has adopted cost sharing for certain services.⁸⁰

However, there is currently an exemption disallowing cost sharing for beneficiaries enrolled in a managed care plan. Thus, because most Florida beneficiaries are enrolled in managed care, cost sharing is not generally an issue in Florida.⁸¹

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.⁸²

Put another way: comparability prohibits the state from providing a different amount, duration and scope of benefits for categorically eligible people. Thus, there cannot be discrimination between recipients based on their eligibility category, i.e. family Medicaid v. disability Medicaid or based their diagnosis. For example, if the state covers behavioral treatments but then excludes coverage of any behavioral treatments based on diagnosis that would violate comparability.⁸³

REASONABLE PROMPTNESS

In contrast to the time standards for determining eligibility (45 days for determination based on family related and 90 days for determination based on SSI related Medicaid), the federal law does not provide numeric standards for what constitutes “reasonable promptness” for services. Thus, disputes have arisen over what is “reasonably prompt” for different services.⁸⁴

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

PROVIDER PARTICIPATION

Another major governing principle is that if provider accepts Medicaid, they have to accept Medicaid as payment in full. With the exception of allowable cost sharing authorized under federal law and the state plan, providers cannot bill patients for services.⁸⁵

MEDICAL NECESSITY

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

adults. Rather, the applicable regulation simply provides that the service must be sufficient in “amount, duration, and scope” to achieve its purpose.⁸⁶

Individual states have significant flexibility in setting amount, duration and scope standards. Thus, for example, Florida has limited coverage for inpatient hospital stays to 45 days per year. This is a “reasonable” limit because it is sufficient in amount to cover the inpatient hospital needs of most adult beneficiaries.⁸⁷

By contrast, Florida (and other states) cannot limit the coverage of services for recipients under 21, as long as the service is medically necessary for the individual child. Thus, for example, the state rule for hospital services allows for coverage of medically necessary services of up to 365 days for recipients under age 21.

FLORIDA'S DEFINITION OF MEDICAL NECESSITY⁸⁸

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed

diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT

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

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

outreach and informing, appointment scheduling and transportation assistance.

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

MEDICAL SCREENS

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

1. A comprehensive health and developmental history, 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; and
5. Health education and anticipatory guidance.

Medical screens must be provided according to a "periodicity schedule." ⁸⁹

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 and diagnosis and treatment of vision defects, including eyeglasses.

- Hearing services must include hearing screens and diagnosis and treatment for defects in hearing, including hearing aids.
- Dental services must include dental screens, relief of pain and infections, restoration of teeth, and maintenance of dental health.

Vision, hearing and dental services must each be provided according to individual periodicity schedules.⁹⁰

INTERPERIODIC, OR “AS NEEDED” SCREENS

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

Persons outside the health care system (for example, a teacher or parent) can determine the need for an interperiodic screen. Any encounter with a health care professional acting within the scope of practice is considered to be an interperiodic screen, even if the provider is not participating in the Medicaid program at the time the screening services are furnished.⁹¹

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. . .”⁹² This includes all mandatory and optional services that the state can cover under Medicaid, whether or not such services are covered for adults.⁹³

For example, if a child needs personal care services to ameliorate a behavioral health problem, then 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.⁹⁴

Further, the agency must “arrange for (directly or through referral to appropriate agencies, organizations or individuals) corrective treatment.”⁹⁵

INFORMING ELIGIBLE FAMILIES ABOUT EPSDT

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

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

SECTION FIVE: MANAGED CARE

BACKGROUND

Florida was one of the first states to mandate enrollment in managed care plans. In 2006, the state received approval for a section 1115 Waiver⁹⁶ that shifted Medicaid beneficiaries out of a fee-for-service delivery model (also referred to as “traditional” or “straight” Medicaid) into a managed care system.

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

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

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

There is a significant amount of material on AHCA’s website include a helpful “snapshot” of the MMA program that describes multiple aspects of the program including the plans that are available in each region.⁹⁷

ENROLLMENT POPULATION

As noted, most Medicaid recipients are required to receive their covered services through a managed care health plan.⁹⁸ The voluntary enrollment population for MMA program, as well as the population excluded from the entire SMMC managed care program, are bulleted below.

*Who may (but need not) enroll in MMA?*⁹⁹

- 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 developmental disabilities home and community based services waiver or

Medicaid recipients waiting for waiver services

- Children receiving services in a prescribed pediatric extended care center
- Recipients residing in a group home facility licensed under Fla. Stat. Chapter 393, or are age 65 or older and residing in a mental health treatment facility under Fla. Stat. Chapter 394

Who may not enroll in SMMC? ¹⁰⁰

- Presumptively eligible pregnant women or women eligible only for family planning services
- Women who are eligible through the breast and cervical cancer services program
- Residents in an emergency shelter or Department or Juvenile Justice facility
- Persons who are eligible for emergency Medicaid for aliens or the Medically Needy program
- Certain full-benefit dual-eligible recipients enrolled in particular Part C Medicare Advantage plans
- Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI)

ENROLLMENT PROCESS

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

their application for Medicaid, applicants will:

- receives information about managed care plan choices in their area;
 - be informed of their options in selecting an authorized managed care plan;
 - be provided the opportunity to meet or speak with a choice counselor; and
 - be given the opportunity to indicate a plan choice selection if they are prepared to do so.
-
- If an individual is determined to be eligible for Medicaid and a health plan has not been selected during the application process, they will be enrolled into a plan through auto-assignment.
 - Through this process, also referred to as “Express Enrollment,” health plan enrollment will be effective the same day that the recipient’s eligibility application is approved.
 - Selecting a Plan:
 - To find MMA health plan availability, see: http://ahca.myflorida.com/Medicaid/statewide_mc/pd/f/mma/SMMC_MMA_Snaps hot.pdf

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

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

MANAGED CARE SERVICES

What services must be covered?

At a minimum, all managed care plans must provide specified services that are enumerated in AHCA's Model Contract, Section V¹⁰¹:

- If questions arise as to whether or not a prescribed service is covered, it is important to reference the Florida Rule for that specific service. Each rule references a particular "*Provider Services Coverage and Limitations Handbook*," which details the type and scope of services covered.¹⁰²
- After enrollment into a health plan, recipients should receive a

Member Handbook from their particular managed care provider detailing the services they are entitled to receive and information on how to contact the plan if a problem arises.

- The member handbook can also be found online or by calling the customer service representative for the particular plan.
- Certain Medicaid services are not covered by MMA health plans, but are still available to eligible recipients through traditional fee-for-service Medicaid.
- Some important non-MMA services include Applied Behavioral Analysis (ABA), Early Intervention Services (EIS), and Medical Foster Care.

What access standards apply to the health plans?

An important goal of the MMA program and the 2016 federal Medicaid managed care regulations is ensuring that plans have sufficiently robust networks so that enrollees can access services in a timely manner. The legislation implementing Florida's MMA program specifically mandates that:

- “The 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.”¹⁰³

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

Primary Care - within 20 miles/30 minutes (urban or rural)

Specialists – (depending on the specialist) between 50-100 minutes/35-75 miles (urban); 60-110 minutes/45-90 miles (rural)

Facilities/Hospitals – within 30 minutes/20 miles (urban or rural)

Behavioral Health - within 30 minutes/20 (urban); 60 minutes/45 miles (urban)

APPOINTMENT ACESST STANDARDS:¹⁰⁴

Urgent Care - within one (1) day of the request

Sick Care - within one (1) week of the request

Well Care Visit - within one (1) month of request.

TRAVEL TIME/DISTANCE STANDARDS:¹⁰⁵

CHANGING PLANS / DISENROLLING

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

- For good cause, at any time.
- Without cause, for mandatory enrollees within the first 120 days after enrollment or broker sends notice of enrollment (whichever is later).¹⁰⁶
- Without cause, for voluntary enrollees at any time.

After 120 days, recipients may only change plans for “good cause.” After the 12-month period, recipients may change plans during the open enrollment period.

- To change their plan, beneficiaries can speak with choice counselors, who are available to assist recipients in selecting a plan that best fits their needs.

“Good cause” is required to change plans after 120 days

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

The following reasons constitute good cause for disenrollment:¹⁰⁷

- 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
- 10) MCP, as specified in 42 CFR § 438.702(a)(4).
- 11) 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.
- 12) The MCP does not, because of moral or religious objections, cover the service the enrollee seeks.
- 13) The enrollee missed open enrollment due to a temporary loss of eligibility.
- Other reasons per 42 C.F.R. § 438.56(d)(2) and Fla. Stat. § 409.969(2), include, but are not limited to:
- a. poor quality of care;
 - b. lack of access to services covered under the Contract;
 - c. inordinate or inappropriate changes of PCPs;
 - d. service access impairments due to significant changes in the geographic location of services;
 - e. an unreasonable delay or denial of service;
 - f. lack of access to providers experienced in dealing with the

- enrollee's health care needs; or
- g. fraudulent enrollment.

FILING A COMPLAINT

Enrollees who are having trouble accessing services or who are encountering other problems with their SMMC services can file an official complaint.

- A complaint may be filed either online at https://apps.ahca.myflorida.com/s mmc_cirts/ [recommended for all issues] or by speaking with a Medicaid representative by calling toll free 1-877-254-1055 to speak to a Medicaid representative.
- AHCA's online portal gives those filing a complaint the option to remain anonymous. However, if there is an issue that needs to be resolved, the person filing the complaint should provide their name and an email address or phone number.
- AHCA uses this process both to resolve individual issues and to assist and help identify systemic problems.

Steps in filing an online complaint:

- First, under the **Complainant Information** section, the complainant must choose whether they are the Medicaid recipient or healthcare provider, or filing on behalf of the recipient or provider. The complainant can choose to either enter their name, email (if

available), and phone number, or leave it blank.

- Next, under the '**Who is the complaint/issue about?**' section, the complainant will enter the recipient's name, gold card, SSN, or Medicaid number, the county of residence, whether a previous complaint has been filed with AHCA, the type of managed care plan, the name of the managed care plan, and whether the complainant has contacted the plan.
- Finally, under the '**Please complete all choices that relate to your issue**' section, the complainant can indicate the type of complaint, e.g. having trouble obtaining a specific service.

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

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.¹⁰⁸ 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.

¹⁰⁹

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 plan approved 1 hour/week for one month);
- Failure to provide service in a timely manner as defined by the State;
- Failure of plan to act within required timeframes for resolution of grievance or appeal; and
- Denial in whole or in part of payment for a service of a request to dispute cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.¹¹⁰

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.

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.¹¹¹

Is there a statutory right to a fair hearing?

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

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

Enrollees must first exhaust the plan’s appeal process. Thus, a fair hearing can only be requested after notice that the adverse benefit determination has been upheld in the plan appeal process¹¹²

Are there any exceptions to exhaustion requirement?

Yes. If the plan does not follow the notice and timing requirements in 42 C.F.R. § 438.404(c), the enrollee is “deemed to have exhausted” the plan appeal process and can request a state fair hearing.¹¹³

What constitutes adequate notice?

The notice must include the following information:

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

- 3) Right to request an appeal, including:
 - Information on exhausting one level of appeal
 - Right to request a state fair hearing
- 4) Process for appeal
- 5) Circumstances for an expedited appeal and how to request
- 6) Right to have benefits continue pending resolution of appeal, including:
 - How to request continued benefits
 - Circumstances under which enrollee may be required to pay

Additionally, the notice must be accessible to individuals with disabilities or limited English proficiency.¹¹⁴

What time standards apply to various notices?

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

- notice must be sent within 72 hours.
- 5) If service authorization is not reached within the time frame specified in 42 C.F.R. § 438.210(d), this constitutes a denial on the date that the timeframe expired.
¹¹⁵

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.”¹¹⁶

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.)¹¹⁷ The best practice is to file in writing with the plan. The enrollee handbook is required to include the necessary information for doing so.¹¹⁸

The plan must provide written notice acknowledging the receipt of the grievance or appeal within five business days.¹¹⁹

Where to file fair hearings and who are the parties?

Pursuant to 2016 legislation, Medicaid appeals related to services for persons enrolled in a managed care plan and which are filed on or after March 1, 2017, are directed to AHCA. Fla. Stat. § 409.285(2).

Prior to March 1, 2017, fair hearing requests were filed with DCF and named AHCA as the respondent. AHCA would then file a motion to join the plan, and DCF hearing rules at F.A.C. 65-2 apply. Under the 2017 rules, the managed care organization is the respondent, and “upon request by AHCA, the Agency may be granted party status by the Hearing Officer.”¹²⁰

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

suspension, or reduction of a previously authorized medical service, he or she 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 individualized was recognized by the United States Supreme Court in the seminal case of *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970). Accordingly, services must be continued if all of the following occur:

- Appeal involves termination, suspension, or reduction of previously authorized service
- Services 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.¹²¹

If the beneficiary is provided with continued coverage of the service and ultimately loses the appeal, the cost of the service can be recouped.¹²²

What are enrollee rights in grievances and appeals?

Enrollees have the right to:

- make legal and factual arguments in person and in writing. 42 C.F.R. § 438.406(b)(4)
- present evidence, including new evidence not available at

- time of decision, 42 C.F.R. § 438.406(b)(5)
- o review medical records and case file free of charge and in advance.

The Model Contract includes all of the above except the right to review of medical records and file free of charge.¹²³

Discovery and subpoenas

Florida is one of the only states that allows full discovery in fair hearing process, including for hearings related to managed care. AHCA's managed care fair hearing rule provides that the Florida Rules of Civil Procedure apply and the Hearing Office may issue orders to "effect the purpose of discovery and to prevent delay."¹²⁴

ADVOCATE TIP:

Discovery can be helpful, including:

- requests for production of documents,
- requests for admission,
- depositions.¹²⁵

*What are the time standards for filing and resolving grievances and appeals and what notice is required?*¹²⁶,¹²⁷

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

- Grievance – can be filed at any time and must be decided within 90 days

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

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

The plan must send a written notice of the appeal resolution that includes:

- results of resolution process and completion date; and if the result was not completely in favor of the enrollee, the notice must include:
 - o information about the right to request a fair hearing and how to do so, and
 - o information on the right to continued benefits.¹²⁸

RELEVANT AUTHORITY

There are multiple authorities enumerated below which relate to Florida's MMA program, including federal and state regulations (rules); Florida statutory provisions, contractual provisions between AHCA and the 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 final regulations in April 2016.

Florida Statutes

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes directing the Agency to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: the Managed Medical Assistance program (MMA) and the Long-Term Care program (not included in this *Guide*).

AHCA's Model Contract

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

- Attachment I re: Scope of Services, February 2018,
http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2018-02-01/Attachment_I_Scope_of_Services_Feb_1_2018.pdf
- Attachment II re: Core Contract Provisions, February 1, 2018

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2018-02-01/Attachment_II_Core_Contract_Provisions_Feb_1_2018.pdf

- Attachment II, Exhibit II-A re: MMA Program, February 1, 2018, [http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2018-02-01/EXHIBIT_II-A_MMA_Managed_Medical_Assistance_\(MMA\)_Program_Feb_1_2018.pdf](http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2018-02-01/EXHIBIT_II-A_MMA_Managed_Medical_Assistance_(MMA)_Program_Feb_1_2018.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.

On August 3, 2017, CMS issued new STCs pertaining to the Waiver's approval period from August 2017 through June 2022, available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-ca.pdf>.

Florida Administrative Rules

The state's relevant administrative rules pertaining to various covered medical

services are found at Fla. Admin. Code Rule (or F.A.C.) 59G-4.010 *et seq.*

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

Finally, fair hearings related to Medicaid managed care are conducted by AHCA as described at 59G-1.100.

APPENDIX

1: Managed Care Assistance Program Minimum Covered Services

2: Filing and Resolution Time Frames

Appendix 1: Managed Care Assistance Program Minimum Covered Services

Advanced registered nurse practitioner services	Laboratory and imaging services
Ambulatory surgical treatment center services	Medical supply, equipment, prostheses and orthoses
Assistive Care Services	Mental health services
Birthing center services	Nursing care
Chiropractic services	Optical services and supplies
Dental services	Optometrist services
Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy
Emergency services	Podiatric services
Family planning services and supplies (some exception)	Physician services, including physician assistant services
Health Start Services (some exceptions)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Health inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services

Appendix 2 :Filing and Resolution Time Frames

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

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

² 26 U.S.C. § 36B (c)(1)(A).

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

⁴ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012)

⁵ Florida Department of Children and Families, Program Policy Manual, (Mar. 20, 2018), <http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cashprogram-policy-manual>.

⁶ Centers for Medicare & Medicaid Services, CMS Regional Offices, (Mar. 20, 2018), <https://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/RegionalMap.html>.

⁷ 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, 2017 Through September 30, 2018, 81 FR 80078-0, <https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-27424.pdf>.

⁸ 42 U.S.C. § 1396d(y)(1).

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

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

¹¹ 42 U.S.C. §1396a(a)(10)(A)(i), Fla. Stat. Fla. Stat. § 409.903,, Fla. Code Admin. Code 65A-1.703; Fla. Admin. Code 65A-1.710 .

¹² Screening for Medicaid Eligibility Under the Pickle Amendment, <http://povertylaw.org/clearinghouse/pickle>.

¹³ 42 U.S. Code § 1396b(v); 42 C.F.R. §435.406(b); 42 C.F.R. § 440.255; Fla. Stat. §§ 409.902(2)(b); 409.904(4); Fla. Admin. Code R. 65A-1.301(1); Fla. Admin. Code R. 65A-1.702(c); Fla. Admin. Code R. 59G-1.050(4).

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

¹⁵ Fla. Stat. §§ 409.904(1), Fla. Admin. Code 65A-1.710(1); *see also* <http://ahca.myflorida.com/Medicaid/MEDS-AD/index.shtml>; SSI RELATED MEDICAID PROGRAMS FACT SHEET at 6, <http://www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf>.

¹⁶ In December 2017, CMS approved an amendment to the state's 1115 Waiver to include HIV patients who meet a hospital level of care (including many previously enrolled in PAC HCBS Waiver) into MMA up to 300% of FPL and Dec 2017 waiver amendment. CMS, LETTER RE MANAGED MEDICAL ASSISTANCE (MMA) PROGRAM (2017),

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-ca.pdf>.

¹⁷ Fla. Stat. §409.904(6).

¹⁸ 42 C.F.R. § 435.600 *et. seq.*; see DCF Family related income eligibility chart specifying the income limits under each category per household size.

http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_07.pdf

NOTE: The income chart is accurate in terms of numeric income levels. However, the chart's inclusion of two columns for different disregards: i.e. the "standard disregard" and the MAGI disregard" is not technically correct. Under the federal regulation, MAGI is only one disregard. The pre-ACA "standard disregard" was essentially incorporated into the eligibility standards when Florida and other states converted to MAGI and established new eligibility levels.

¹⁹ <http://www.healthlaw.org/publications/browse-all-publications/agmagi#.Wr0bu6ZPEZ>.

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

²¹ *Id.*

²² *Id.*

²³ 42 C.F.R. § 435.603(e).

²⁴ 42 C.F.R. § 435.603(d).

²⁵ As of the date of publication of this Guide, Florida has not yet amended the state administrative rules to conform to the federal regulation. *Compare* Fla. Admin. Code R. 65A-1.702, .703, .704, .705, .707, .708, .716 with 42 C.F.R. §435.603(d)-(f).

²⁶ Fla. Admin. Code R. 65A-1.710, *see also* SSI RELATED MEDICAID PROGRAMS FACT SHEET at 6-7, <http://www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf>.

²⁷ Fla. Admin. Code R. 65A-1.716(5)(a).

²⁸ Fla. Admin. Code R. 65A-1.712.

²⁹ Fla. Admin. Code R. 65A-1.712(1)(a); SSI-Related Programs - Financial Eligibility Standards: April 1, 2018, https://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf.

³⁰ 20 C.F.R. § 416.1201(a).

³¹ 42 U.S.C. §1382b(a).

³² "Consider the resource value of a life insurance policy to be its cash surrender value (CSV), not its face value (FV)." SSA, POMS, SI 01130.300 C.1 (November 14, 2013).

³³ "If an individual (claimant, recipient, or deemor) has legal authority to revoke or terminate the trust and then use the funds to meet his food or shelter needs, or if the individual can direct the use of the trust principal for his or her support and maintenance under the terms of the trust, the trust principal is a resource for SSI purposes. Additionally, if the individual can sell his or her beneficial interest in the trust, that interest is a resource." SSA, POMS, SI 01120.200 D.1.a. (Dec. 11, 2013); This Guide is not addressing other resource related provision including e.g. special needs trusts.

³⁴ 20 C.F.R. § 416.1201(a)(1).

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

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

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

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

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

⁴⁰ 42 U.S.C. § 1396b(v)(4)(A); Fla. Stat. § 409.811(17); Fla. Stat. § 409.904(8); Children's Health Improvement Act (CHIA) Conference Committee Amendments, HB 5101 <https://www.flsenate.gov/Session/Bill/2016/5101/Amendment/413601/PDF>

⁴¹ 42 U.S.C. § 1396a(b)(2); 42 C.F.R. § 435.403; Fla. Admin. Code R. 65A-1.705(5), DCF Policy Manual § 1430.0300; DCF Policy Manual § 1440.0300.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ Florida DCF TRANSMITTAL NO.: P-17-10-0020, http://cdn.trustedpartner.com/docs/library/PalmBeachTreasureCoast2112015/DCF%20Policy_Assisting%20Families%20from%20Puerto%20Rico%5B183%5D.pdf

DCF transmittal: "[i]f an individual/household reports they are an evacuee from Puerto Rico, apply current policies and procedures when determining eligibility for Medicaid Programs. Evacuees from Puerto Rico who have the intent to reside in Florida, meet the residency requirement. Residency is not contingent on the length of the stay. If the individual/household states an intent to return but has no plans to do so in the foreseeable future, they can be considered a resident of Florida. Residency does not exist if the evacuee states they are temporarily staying in Florida and have plans to return to Puerto Rico; and, therefore the individual/household is not eligible for Medicaid. All other financial and technical criteria must be met when determining eligibility for Medicaid."

⁴⁵ Fla. Admin. Code R. 65A-1.302; DCF Policy Manual 1430.0200; 1430.0204; 42 C.F.R. § 435.910. Note: The federal regulation policy allows for an exception based on a "well established religious objection," 42 C.F.R. § 435.910(h); the state rule allows for "good cause" failure to provide SSN Fla. Admin. Code R. 65A-1.302 (3); however the DCF program manual does not provide for any exceptions. *See* 1430.0200; 1430.0204.

⁴⁶ 42 U.S.C. § 1396d (r)(5); Fla. Admin. Code R. 65A-1.702(6).

⁴⁷ Fla. Admin. Code R. 65A-1.702(5).

⁴⁸ 42 U.S. C. § 1396a(a)(34); 42 C.F.R. § 435.914, Fla. Admin. Code R. 65A-1.702(2)(9).

⁴⁹ HB 5001: General Appropriations Act at 55, (March 16, 2018), <https://www.flsenate.gov/Session/Bill/2018/5001/?Tab=BillText>; Florida Managed Medical Assistance Waiver Public Notice Document at 5, AHCA (March 21 - April 19, 2018) http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1115_MMA_Public_Note_Doc_LIP_Retroactive_Eligibility_2018-03.pdf

⁵⁰ See *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981).

⁵¹ Fla. Stat. § 409.902(1).

⁵² Fla. Admin. Code R. 65A-1.205, 42 U.S.C. § 18083; 42 U.S.C. § 1396w-3; *Frequently Asked Questions*, Department of Children and Families, <http://www.myflfamilies.com/service-programs/access-florida/faq>;

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

⁵⁴ Fla. Admin. Code R. 65A-1.205, 42 U.S.C. §18083; 42 U.S.C. §1396w-3; *Frequently Asked Questions*, Department of Children and Families, <http://www.myflfamilies.com/service-programs/access-florida/faq>.

⁵⁵ 42 C.F.R. §435.911(a)(2); Fla. Admin. Code R. 65A-1.205(1)(b).

⁵⁶ Fla. Admin. Code R. 65-2.066

⁵⁷ See *Pond v. Dep't of Health & Rehab. Servs.* Dist. 7, (Fla. Dist. Ct. App. 1987) (where "a caseworker is presented with specific and revealing information regarding the applicant's eligibility for benefits, that caseworker has an affirmative duty under 45 C.F.R. § 206.10(a)(2)(i) to inform that applicant at least orally of the conditions relevant to her eligibility.

⁵⁸ See *Kurnik v. Department of Health and Rehabilitative Services*, 661 So. 2d 914 (Fla. Dist. Ct. App. 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 "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."

⁵⁹ <http://www.floridahealth.gov/programs-and-services/people-with-disabilities/disability-determinations/index.html>.

⁶⁰ Fla. Admin. Code R. 65A-1.205(1)(b).

⁶¹ Fla. Admin. Code R. 65A-2.042.

⁶² 42 C.F.R. §435.541(c) (2)-(4).

⁶³ The average wait time for applicants to receive an independent hearing before an Administrative Law Judge (ALJ) is (21) is significant, e.g. for Miami it is 22 months. https://www.ssa.gov/appeals/DataSets/01_NetStat_Report.html

⁶⁴ Fla. Admin. Code Rule 65A-1.704(1); 42 CFR § 435.916 .

⁶⁵ 42 CFR § 435. 916.

⁶⁶ Department of Children and Families, TRANSMITTAL No: P 1-14-11-0012 (November 7, 2014), *Automated Family-related Medicaid Renewal Process* (available on the FLAdvocate Health Law website. <https://www.fladvocate.org/healthandsenior>.)

⁶⁷ Department of Children and Families, TRANSMITTAL No: P - 1-14-11- (Nov. 7, 2014), *Gap Coverage for Medicaid Renewals*, (available on the FLAdvocate Health Law website. <https://www.fladvocate.org/healthandsenior>.)

⁶⁸ 42 C.F.R. § 435.930, 42 C.F.R. § 435.1003; Fla. Admin. Code R. 65A-1.702(4); Access 0830.0600, see also, Department of Children and Families, TRANSMITTAL No: P - 11-06-0007 (June 7, 2011), *Supplemental Security Income Termination Review Process*, (available on the FLAdvocate Health Law website. <https://www.fladvocate.org/healthandsenior>.)

⁶⁹ U.S. CONST. amend .XIV, § 1; 42 U.S.C. §1396a(a) (3); 42 C.F.R. §§ 431.200-431.246; Fla. Admin. Code R. 65A-2; *.Goldberg v. Kelly*, 397 U.S. 254 (1970).

⁷⁰ *Id.*

⁷¹ 42 C.F.R. § 431.210, Fla. Admin. Code R. 65A-2.043

⁷² Fla. Admin. Code R. 65A-2.057

⁷³ 42. C.F.R. § 431.220 (b).

⁷⁴ 42 U.S.C. § 1396d(r)(5).

⁷⁵ 42 U.S.C. § 1396d(a).

⁷⁶ See, *Smith v. Benson*, 703 F. Supp.2d 1262 (S.D. Fla.) (Challenged state Medicaid rule that excluded coverage of diapers without exception for recipients under age 21.)

⁷⁷ As discussed in the Guide's Section on Medicaid Managed Care, virtually all Florida Medicaid recipients are enrolled in a managed care organization (MCO). Thus, they receive their services through the MCO. The services both mandatory and options which are covered under Florida's Managed care plan contracts are listed in the Appendix.

⁷⁸ Fla. Stat. § 409.905

⁷⁹ Fla. Stat. § 409.906

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

⁸¹ Fla. Stat. §409.9081(3)(f).

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

⁸³ *K.G. ex rel. Garrido v. Dudek*, 981 F. Supp. 2d 1275 (S.D. Fla. 2013), aff'd in part and modified in part, 731 F. 3d 1152 (11th Cir. 2013) (Court entered declaratory judgment finding that AHCA's rule excluding coverage of any behavioral treatments for children with certain diagnoses, including violated Medicaid comparability requirements. Court of Appeals ordered that previously unpublished Declaratory Judgment, including ruling on comparability not addressed in the permanent injunction, be published.).

⁸⁴ *Doe 1-3 ex rel. Doe Sr. 1-13 v. Chiles*, 136 F. 3d 709 (11th Cir. 1998) (finding reasonable promptness provision at 1396a(a)(8) enforceable and requiring state to establish reasonable waiting list time, not to exceed 90 days for individuals eligible for IXCF/MR care.)

⁸⁵ 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).

⁸⁶ 42 C.F.R. § 440.230.

⁸⁷ See *Alexander v. Choate*, 469 U.S. 287 (1985) (holding that Tennessee could "reasonably" limit coverage of inpatient hospital days per year to 11): *Curtis v. Taylor*, 648 F. 2d 946 (5th circ. 1980) (holding that Florida's rule limiting physician visits to 3/month did not violate federal Medicaid law.)

Alexander v. Choate, (no specific page)

⁸⁸ Fla. Admin. Code R. 59G-1.010, *Definitions Policy*, section 2.83 at 7.

⁸⁹ 42 U.S.C. § 1396d (r)(5)(1); AHCA's website specifies the state's schedule for health checkups at the following website, which also specifies that Florida follows the Bright Futures/ American Academy of Pediatrics recommendations.

<http://ahca.myflorida.com/medicaid/childhealthservices/chc-up/index.shtml>.

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

⁹¹ *K.G. ex rel Garrido v. Dudek*, 839 F. Supp. 2d 1254, 1275 (S.D. Fla. 2013) (In granting preliminary injunction, court rejected Defendant's claim that plaintiff cannot show a substantial likelihood of success on the merits because he has failed to allege that his autism was discovered through an "EPSDT" screening, noting that "inter-periodic screens include

any visit to a physician (including family-initiated visits) to determine if the child has a condition requiring further assessment, diagnosis or treatment.”

⁹² 42 U.S.C. § 1396d (r)(5).

⁹³ See, AHCA Model Contract Attachment II, Exhibit II-A, at 5 regarding procedures managed care plans should follow and stating “authorization of any medically necessary service to enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule. The Managed Care Plan shall also include following language verbatim in its enrollee handbooks: [Insert Managed Care Plan name] must provide all medically necessary services for its members who are under age 21. This is the law. This is true even if [Insert Managed Care Plan name] does not cover a service or the service has a limit. As long as your child’s services are medically necessary, services have: • No dollar limits; or • No time limits, like hourly or daily limits.

⁹⁴ *C.F. v. Dept. of Children and Families*, 934 So. 2d 1 (Fla. 3rd DCA 2006)(Successfully challenged the state’s reduction of personal care services (PCA) for severely disabled child. The Court found that the state was using an overly restrictive definition of PCA and medical necessity in violation of federal Medicaid law.)

⁹⁵ 42 C.F.R. § 441.62.

⁹⁶ Sec. 1115 of the Social Security Act allows the Secretary of HHS to waive some requirements of the Medicaid Act so that states can test novel approaches to improving medical assistance for low-income people.

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

⁹⁸ AHCA Model Contract, Attachment II at 47, Section III A. 1. (mandatory enrollment populations)

⁹⁹ Fla. Stat. §409.972, AHCA Model Contract, Attachment II at 47-8, Section III. A. 2.

¹⁰⁰ AHCA Model Contract, Attachment II at 47-8, at 48, Section III A. 3.

¹⁰¹ Services covered by MMA plans, See Appendix at 1.

¹⁰² See Fla. Admin. Code R at 59G-4.013-59G-4.330; AHCA Model Contract, Attachment II, Exhibit II-A at 9-51.

¹⁰³ Fla. Stat. § 409.967(2)(c)(1)

¹⁰⁴ Model Contract, Attachment II, Exhibit II-A at 56-62.

¹⁰⁵ *Id.* at 53-54.

¹⁰⁶ *Id.* at 51-52.

¹⁰⁷ *Id.* at 51-53; Fla. Admin. Code 59G-8.600; see also 42 C.F.R. § 438.56;

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

¹⁰⁹ 42 CFR 438.400(b); Fla. Admin. Code 59G-1.100(2)(b) (definition of “grievance”)

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

¹¹¹ 42 C.F.R. § 438.402(c)(2); Model Contract, SMMC, section IV, (C)(4)(a).

¹¹² 42 C.F.R. § 438.402; Fla. Admin. Code R. 59G-1.100 (3)(b)1; Model Contract, SMMC, at 86 Section IV, (C)(4)(a).

¹¹³ 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.

¹¹⁴ 42 C.F.R. § 438.10, Fla. Admin. Code R. 59G-1.100(2)(t); http://www.fdhc.state.fl.us/medicaid/statewide_mc/smmc_plan_comunications_archive.shtml, linking to a February 24 Policy Transmittal requiring that plans use a template notice. (available on the FLAdvocate Health Law website. <https://www.fladvocate.org/healthandsenior/>).

¹¹⁵ 42 C.F.R. § 438.404(c).

¹¹⁶ 42 C.F.R. § 438.410; Model Contract, Attachment II, Exhibit II Core Contract Provisions at 88, Section IV.C.5.m.

¹¹⁷ Model Contract, Attachment II, Exhibit II Core Contract Provisions at 87, Section IV, C. 5. B. (2); *see also* 42 C.F.R. § 438.406(b)(3).

¹¹⁸ 42 C.F.R. § 438.406.

¹¹⁹ Model Contract, Attachment II, Exhibit II Core Contract Provisions, at 86, Section IV.C.4.b.; *see also*, 42 C.F.R. § 438.406 (b)(1).

¹²⁰ Fla. Admin. Code R. 59G-1.100 (4).

¹²¹ Model Contract, Attachment II, Exhibit II Core Contract Provisions, at 91, Section IV. C.6.i.. 42 C.F.R. § 438.420.

¹²² Model Contract, Attachment II, Exhibit II Core Contract Provisions, at 91, Section IV. C.5.h; Section IV. C.6.k. *see also* 42 C.F.R. § 438.420(d).

¹²³ 42 C.F.R. § 438.406(b)(4)(5); *compare* Model Contract, Attachment II, Exhibit II Core Contract Provisions, Section IV.C. 5.d. at 87. (contract includes all of the provisions in federal regulation except the right to review of medical records and file free of charge).

¹²⁴ Fla. Admin. Code R. 59G-1.100 (13).

¹²⁵ Sample discovery is available on the FLAdvocate Health Law website. <https://www.fladvocate.org/healthandsenior/>.

¹²⁶ Model Contract, Attachment II, Exhibit II Core Contract Provisions, Section IV C. 5,6; 42 C.F.R. 438.408.

¹²⁷ *See Appendix 2, AHCA chart of Filing and Resolving Time Frames.*

¹²⁸ 42 C.F.R. § 438.408(e); Model Contract, Attachment II, Exhibit II Core Contract Provisions, at 89 Section IV. C. 6.n.