FLORIDA HEALTH JUSTICE PROJECT

Medicaid Home & Community Based Services (HCBS)
Know Your Rights!

Low-income Floridians whose disabilities require nursing home level of care may be eligible to receive home and community based services (HCBS) through the state's Long-Term Care (LTC) Medicaid Waiver. Eligible individuals must enroll in a managed care plan in order to receive their HCBS, as well as regular Medicaid services.

Because this critical program is tremendously complicated, the Florida Health Justice Project has prepared an *Advocate's Guide*. This fact sheet is a companion to The *Guide* and lists the key consumer rights afforded by the LTC Waiver. Each consumer right is followed by the page number where it is discussed at greater length in the Guide. Pagination is to the PDF version.

What are my rights at the application stage?

- You have the right to apply and to receive an assessment by phone of your eligibility. (p. 10)
- You have the right to receive written notice of your ranking based on your assessment. (p. 11)
- You have the right to appeal your ranking. (p. 12)
- You have the right to appeal a denial or any delay during the application process. (p. 15)

What are my rights after I am found eligible?

- You have the right to select one of the managed care plans in your region. (p. 15)
- You have the right to an initial meeting with the plan representative to have a care plan developed within five (5) business days of enrollment (p. 17) and to begin receiving services within seven (7) days after the initial meeting. (p. 20)
- You have the right to have a written care plan that specifies the services and supports that will be provided to meet your abilities, needs and preferences, and that includes all of the services prescribed by your doctor. (p. 18)

- You have the right to appeal your care plan if not all of your needed services are included. (p. 18-19)

- You have the right to a "supplemental assessment" that identifies your support system, e.g. family member(s), and includes an assessment of their other responsibilities, stressors and willingness to participate in your care. (p. 19)

- You have the right to disenroll from your plan, and change plans within the first 120 days of enrolling, or after that for "good cause." (p. 16)

- You have the right to receive all services that are prescribed and "medically necessary." (p. 21-22)

- If you leave your home in order to receive the service(s), e.g. adult day care, you should not have to travel more than thirty (30) minutes in an urban county or sixty (60) minutes in a rural county. (p. 23)

- You have the right to receive prescribed services without gaps or interruptions and to receive a "contingency plan" of what to do if a gap occurs. (p. 24)

- You have the right to file a complaint with AHCA, the Medicaid agency, and file a grievance with your managed care plan. (p. 25)

- You have the right to a written notice and an appeal if a new service requested by your provider is denied **or** not approved at the level prescribed, or if a current service is reduced or terminated. (p. 26-28)

- If you receive a notice of reduction or termination, you have the right to continue receiving your current service(s) at the current level(s) if you appeal within ten (10) days of when the notice was sent. (p. 27)

- If you receive a notice of reduction or termination, you have the right to an expedited appeal if a delay could jeopardize your life or health. (p. 26)

- If you receive a notice of reduction or termination, and are not satisfied with the outcome of the plan appeal process, you have the right to a fair hearing. (p. 29-30)