



FLORIDA HEALTH
JUSTICE PROJECT

Advocate's Guide

Florida Long-Term Care Medicaid Waiver

4th Edition
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TABLE OF CONTENTS:

ACKNOWLEDGMENTS.....	3
SECTION ONE: INTRODUCTION	5
WHY THIS GUIDE?.....	5
PURPOSE OF THE GUIDE	5
SECTION TWO: BACKGROUND	5
WHAT ARE MEDICAID WAIVERS?	5
HISTORY AND CURRENT STATUS OF FLORIDA’S LONG-TERM CARE WAIVER.....	6
SECTION THREE: WAIVER OVERVIEW	7
DIFFERENT AGENCIES	7
WAIVER POPULATIONS.....	8
ROLE OF THE MANAGED CARE PLAN	9
SECTION FOUR: WHAT ELIGIBILITY STANDARDS APPLY TO THE LTC PROGRAM?	9
CLINICAL	9
FINANCIAL.....	9
SECTION FIVE: WHAT IS THE APPLICATION PROCESS?	10
APPLICATION STEPS.....	10
SECTION SIX: WHAT IF APPLICATION IS DENIED OR DELAYED?	14
INITIAL ASSESSMENT/PRIORITY RANK	14
AFTER RELEASE FROM WAITING LIST	15
SECTION SEVEN: PLAN ENROLLMENT.....	15
PICKING A PLAN	15
SECTION EIGHT: CHANGING PLANS/DISENROLLING	16
“GOOD CAUSE”	16
EXEMPTIONS FROM THE LTC WAIVER.....	17
SECTION NINE: CARE PLANNING.....	17
INITIAL CONTACT	17
PERSON-CENTERED PLANNING PROCESS.....	18
PERSON-CENTERED PLAN OF CARE.....	19
SUPPLEMENTAL ASSESSMENT	19
ROLE OF CASE MANAGEMENT	20
REASSESSMENT.....	21
PARTICIPANT DIRECTED SERVICES.....	21
SECTION TEN: WHAT SERVICES ARE COVERED	21

SECTION ELEVEN: WHEN MUST COVERED SERVICES BE PROVIDED?	21
SECTION TWELVE: WHAT ARE THE STANDARDS FOR ACCESS AND CONTINUED COVERAGE?	24
TIMELY ACCESS STANDARDS.....	24
CARE COORDINATION AND CONTINUITY	25
SECTION THIRTEEN: WHAT IF SERVICES ARE DENIED, DELAYED, REDUCED OR TERMINATED?	26
FILING AN AHCA COMPLAINT.....	26
GRIEVANCES, APPEALS, AND FAIR HEARINGS	26
WHAT IS AN ADVERSE BENEFIT DETERMINATION (ABD)?.....	28
WHAT NOTICE REQUIREMENTS APPLY?	29
FAIR HEARINGS	30
SECTION FOURTEEN: OTHER ADVOCATE/CONSUMER RESOURCES.....	32
SECTION FIFTEEN: SUMMARY OF RELEVANT AUTHORITY.....	32
APPENDIX	35
1) ABBREVIATIONS.....	35
2) SERVICES	35
3) CARE PLAN	35
4) SUPPLEMENTAL ASSESSMENT FORM.....	35
5) TEMPLATE NOTICE.....	35

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January 2021 (4th Edition)

Updated Acknowledgement:

Advocate Guides need to be regularly updated: laws change, rules change, waiver documents are updated, managed care contracts are amended. Thus, we are deeply grateful to Naomi Stanhaus and the RRF Foundation for Aging whose generous support has made regular updating of this *Guide* possible.

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Miriam Harmatz, Executive Director, Florida Health Justice Project



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SECTION ONE: INTRODUCTION

WHY THIS GUIDE?

It goes without saying that government-subsidized health care benefits are critical for low-income Florida seniors—particularly those who are frail and disabled.

This *Guide* concerns one of the most important health care benefits for this population—the long-term services and supports (“LTSS”) that are essential to being able to remain in one’s home or community rather than having to receive care in a nursing home. Also known as “home and community-based services,” (“HCBS”), these include services not typically available through Medicare or standard medical insurance, such as personal care aides and private duty nursing. Nationwide, over half of people turning 65 will at some point develop a severe disability or medical condition that will require HCBS.¹

In Florida, HCBS for adults are available under the Statewide Medicaid Managed Care system. Long-term care – including both nursing home care and HCBS –are both part of Florida’s “Long-Term Care Program.”² This Guide, however, focuses exclusively on the portion of the LTC Program that provides HCBS, (the “LTC Waiver.”) While the LTC Waiver has a

cap on the number of individuals served and a wait list for enrollment,³ that should not deter individuals from applying.

PURPOSE OF THE GUIDE

This *Guide* provides advocates with an overview of the authority governing Florida’s Medicaid Managed Care Long-term Care (LTC) Waiver and a roadmap addressing basic questions including:

- Who is eligible for the LTC Waiver
- How to apply
- What to do if an application is denied or delayed
- How does the wait list work
- What to do if eligibility is terminated
- What services are covered and how is the “care plan” developed
- How does managed care work
- What to do if services are denied, delayed, terminated or reduced

SECTION TWO: BACKGROUND

WHAT ARE MEDICAID WAIVERS?

Under waiver programs, states can “waive” certain requirements in the Medicaid Act with permission of the federal government. For example, a waiver program allows states to provide care for people who might not otherwise be eligible under Medicaid;

provide services that are not necessarily medical in nature, or implement a managed care system. Florida's current Long-Term Care Waiver operates through two separate waivers authorized under Social Security Act Sections 1915(b) (for managed care) and (c) (HCBS).

Section 1915(c), authorizing Medicaid HCBS waivers, was enacted by Congress in 1983. HCBS waivers allow states to provide home and community support services to a specified number of individuals as an alternative to institutional care.⁴ All individuals enrolled in a HCBS waiver must meet an institutional level of care.⁵

To facilitate these programs, the federal government can waive general Medicaid rules that programs be available throughout a state (statewideness)(?) and to all eligibility groups (comparability), and also offer more lenient financial eligibility standards.⁶ In addition, Section 1915(b) of the Social Security Act provides authority for states to require enrollment in managed care by waiving the rule that beneficiaries are free to choose their providers.⁷

Because states are allowed to limit enrollment in HCBS waivers,⁸ eligible individuals who meet the clinical and financial eligibility requirements for HCBS can nonetheless be put on a

waiting list. By contrast, similarly eligible individuals seeking nursing home placement cannot be put on a wait list.⁹

HISTORY AND CURRENT STATUS OF FLORIDA'S LONG-TERM CARE WAIVER

In 2011, the Florida Legislature established a statewide integrated managed care program for all covered services, including long-term care.¹⁰ The new statewide program included the "managed medical assistance (MMA) program" for delivery of primary and acute medical assistance, and the long-term care ("LTC") managed care program.¹¹

Under a managed care delivery model, the state contracts with private entities, including managed care organizations to "manage" the health care needs of their enrollees using their own network of providers. These managed care organizations (hereafter referred to as the "Plans") act as the gatekeepers for authorization of services and referrals to network providers for covered services.

After a public comment period, the Agency for Health Care Administration (AHCA) submitted two waiver applications to the Center for Medicaid and Medicare Services, (CMS), the federal agency responsible for administering Medicaid. In 2013 CMS

granted approval under both to provide HCBS through the Statewide Medicaid Long -Term Care Program. (Hereafter the “LTC Waiver”).

In 2016, AHCA requested a five (5) year renewal of both the 1915(b) and (c) waivers to continue its LTC Waiver. The 1915 (c) renewal application, a 233-page document, reiterated the purpose, i.e, to *“provide a choice of long-term home and community-based services for eligible and disabled adults in Florida as an alternative to nursing facility services for their long-term care . . . to provide incentives to serve recipients in the least restrictive setting . . .and [to] improve access to care and quality of care.”*¹²

It also included detailed descriptions of the services to be offered, the case management process for developing a care plan, and other procedures designed to ensure that due process is protected.¹³

On December 19, 2016, CMS approved the renewal requests, including approval of an annual number of unduplicated recipients of 62,500 for each year of the waiver.¹⁴

Since that time, there have been several updates to the waiver which provided for increases in the number of unduplicated participants served each year, as well as the number of maximum number of participants

served at any point during the year.¹⁵ The current approved application is from December 2020 and can be found on AHCA’s website.¹⁶

Most notably, the current waiver approval increases the maximum number of unduplicated participants to 98,327, and the maximum number of participants served at any one time during the year to 76,000.¹⁷ The waiver applications, which contain multiple terms and conditions, are posted online and cited throughout this *Guide*. Advocates should be familiar with these documents, as they provide extensive detail describing how the State will operate the Program and form the basis for the federal government’s approval of the Waiver and the amendment request.¹⁸

SECTION THREE: WAIVER OVERVIEW

DIFFERENT AGENCIES

Federal law requires each state to administer its Medicaid program through a single state agency.¹⁹ The designated state agency in Florida is the Agency for Health Care Administration (AHCA).²⁰

Thus, AHCA is ultimately responsible for ensuring that the LTC Waiver complies with all aspects of federal and state law, including the promulgation of appropriate administrative rules, and development of contracts between

AHCA and the Plans that accurately reflect federal and state statutes and regulations.

AHCA administers the waiver in partnership with, the Department of Elder Affairs (DOEA), which maintains the statewide wait list for the LTC Waiver and assists with enrollment. DOEA is also responsible for determining clinical eligibility through its CARES program.²¹ The Department of Children and Families (DCF) is responsible for determining financial eligibility.²²

WAIVER POPULATIONS

The 2011 Florida statute establishing the statewide integrated managed care program described the populations required to enroll as including beneficiaries needing a nursing home level of care who are: 1) age 18 and older, who are eligible for Medicaid due to blindness or disability or 2) age 65 or older who are eligible for Medicaid based on age.²³ Following CMS's approval, enrollees in four existing HCBS waivers were transitioned into the LTC Waiver: (1) the Aged/ Disabled Waiver, (2) the Assisted Living Waiver, (3) the Channeling for the Frail Elderly Waiver, and (4) the Nursing Home Diversion Waiver.

In 2017, state legislation was passed directing AHCA to consolidate three

additional adult HCBS waiver populations (Project AIDS Care, Traumatic Brain and Spinal Cord and Adult Cystic Fibrosis) into the Long-term Care (LTC) Waiver. Pursuant to the statute, eligible individuals from each of those waivers were transitioned into the LTC Waiver in January 2018.²⁴

PACE:

Advocates and consumers should be aware of Programs of All-Inclusive Care for the Elderly ("PACE"). The PACE program, like the LTC Medicaid managed care program, is an alternative to nursing home care or other care facilities.

PACE programs establish centers for Medicaid or Medicare recipients to receive services covered by Medicaid and Medicare. Unlike Long-Term Care service eligibility, placement in a PACE program is age-based. To receive PACE services, applicants must: 1) be 55 or older, 2) live in the service area of a PACE organization, 3) need a nursing home-level of care, and 4) be able to live safely in the community with help from PACE.²⁵ Enrollees receive all medical services and prescription drugs covered by Medicare and Medicaid on site of the PACE program. Enrollees also receive transportation, home care, checkups, hospital visits, and nursing home stays when necessary. For individuals that have

both Medicaid and Medicare, PACE program enrollment is fully covered financially. Those who receive only Medicare will pay a monthly premium.

26

ROLE OF THE MANAGED CARE PLAN

As discussed more fully below, all Plans operate under the same Core Contract with AHCA which requires provision of covered services that are “medically necessary” for the individual enrollee. The case manager, the main point of contact between the enrollee, helps develop a “plan of care,” and is responsible for providing ongoing assistance in obtaining necessary services.²⁷

SECTION FOUR: WHAT ELIGIBILITY STANDARDS APPLY TO THE LTC PROGRAM?

CLINICAL

In order to meet clinical eligibility, applicants must require a “nursing facility level of care.”²⁸ Determining if the applicant requires nursing facility care (also referred to “the level of care determination”) is done by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program.²⁹

FINANCIAL

Financial eligibility is determined by the Department of Children & Families (DCF) pursuant to SSI- Related Medicaid rules.³⁰ If an LTC Waiver applicant is already Medicaid-eligible because he or she receives Supplemental Security Income, DCF does not need a new application.

The 2021 income limit for HCBS waiver programs is 300% of the SSI income limit, or \$2,382 per month for an individual, and \$ 4,764/month for couples who are both eligible.³¹ Applicants for the LTC Waiver whose income is over this amount may still qualify by establishing an income trust that receives the person’s “excess” monthly income.³² The asset limit is \$2,000 for an individual and \$3,000 for a couple, not including certain exempted assets, such as the homestead or a vehicle.³³

Advocate Tip

Financial eligibility is complicated, and this Guide does not attempt to address Medicaid planning for persons whose assets or income exceed the Medicaid limits, or for couples where only one spouse requires LTC Medicaid. These applicants should find either a local legal aid or elder law attorney with expertise.

SECTION FIVE: WHAT IS THE APPLICATION PROCESS?

APPLICATION STEPS

Step 1: Make an appointment to be screened for LTC Waiver wait list priority.

For most applicants, the first step is contacting the local Aging & Disability Resource Center (ADRC) or the Elder Helpline at 1-800-96-ELDER (1-800-963-5337). Florida has eleven (11) ADRCs and the contact information for the applicable office can be found at the [Department of Elder Affairs website](#).³⁴ Relevant contact information for each region is also included in the Appendix.

Advocate Tip

Indicate directly to the ADRC that you want to apply for the LTC Waiver program. Persons with cognitive or communication related disabilities can request a “reasonable modification” such as an in-person assessment. The modification request should be made during the initial call to the ADRC and followed up with a written request.

The Department of Elder Affairs (DOEA) has a [handbook](#) on their website that describes the intake,

screening, prioritization, assessment, and case management processes.³⁵

Some ADRCs will either do an initial assessment, called the 701S, at the time of the call or set an appointment. Other ADRCs will send a letter scheduling a telephone appointment for the initial assessment.

For individuals who are already receiving Older American Act (OAA) services through a community provider, there is also a 701 A assessment. This is an in-person assessment performed by the agency providing the individual’s home-based services, such as personal care and home delivered meals.³⁶ The 701A gathers much of the same data items as the 701S and, as with the 701S, the 701A, will result in a priority score. The provider Agency completing the 701A submits it to the ADRC.

However, even though the 701A is done in person and produces a priority score, the ADRC is still required to provide a 701S.

Step 2: The 701S Assessment and Waiver Prioritization

The ADRC telephonic assessment of needs uses the 701S Screening Form.³⁷ This form gives a “priority score” that measures both the applicant’s need for assistance as well as what caregiver resources are currently available.³⁸

The interviewer will ask for information including: if the applicant lives alone or has a caregiver; the caregiver's health status and ability to continue to provide care; the applicant's present health and how it compares to the prior year; how the applicant's health may limit preferred activities; assistance needed with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)³⁹; and health care resources available to the applicant, including access to health care and medications.⁴⁰

Advocate Tip:

Because the 701S form measures both the applicant's need for assistance and the caregiver resources currently available, it is important to underscore exactly what the applicant cannot accomplish independently, be realistic about what a caregiver can actually do, and underscore any questions/concerns about the caretaker's sustainability.

It is also important to listen carefully to the question, to answer carefully and to request clarification whenever necessary.^{41,42}

Once the 701S form is completed, the ADRC will calculate the priority score and assign a frailty-based level or category referred to as a "rank."⁴³ The individual is scored using a matrix.⁴⁴ An individual is prioritized for LTC waiver services based on their score and rank:

- Rank 1: 0-15.
- Rank 2: 16-29.
- Rank 3: 30-39.
- Rank 4: 40-45.
- Rank 5: Greater than or equal to 46.

The Medicaid rule regarding LTC prioritization specifies three (3) additional categories of individuals listed above the rank of 5 regardless of their priority score.⁴⁵ Those include:

- Rank 6: Aging Out Referral (individuals in disability programs who reach the maximum age for those programs).
- Rank 7: Imminent Risk of Nursing Home Placement.
- Rank 8: Adult Protective Services High Risk Referral

Designated groups who skip steps 1 and 2:

The Florida Legislature specified three (3) categories of individuals who are entitled to priority enrollment for home and community-based services under the LTC Waiver.⁴⁶ Those

individuals, described below, move directly to step 3 and do not have to participate in the 701S screening assessment or wait-list process:

- An individual who is 18, 19, or 20 years of age who has a chronic debilitating disease or condition of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.
- A nursing facility resident who requests to transition into the community and who has resided in a Florida licensed skilled nursing facility for at least 60 consecutive days.
- An individual who is referred by the Department of Children and Families pursuant to the Adult Protective Services Act, ss. 415.101-415.113, as high risk and who is placed in an assisted living facility temporarily funded by the Department of Children and Families.

According to state rule, someone is considered to be at “imminent risk” if the applicant is: unable to perform self-care because of deteriorating mental or physical health condition(s); there is no capable caregiver; and placement in a nursing facility is likely

within a month, or very likely within three months.⁴⁷

Advocate Tip:
If an applicant is at imminent risk of being placed in a nursing home, it is important to describe to the 701S assessor in detail how the person meets each prong of the definition.

Step 3: Release from the waitlist and determination of clinical/financial eligibility

The Department of Elder Affairs (DOEA) has an operational manual which details the process by which individuals are released from the wait list and proceed through the eligibility and enrollment process.⁴⁸ (hereafter “EMS Manual.”)⁴⁹

Pursuant to the EMS Manual, DOEA will notify local ADRCs when waiver slots have been released, and the ADRC then contacts those individuals included in the release list.⁵⁰ After confirming that the individual is still in need of long-term care services, the ADRC sends a written notification of wait list release. This notice includes information on the enrollment process and the instructions and timeframes for completing eligibility.⁵¹

Clinical and financial eligibility

Following release from the wait list, two determinations are necessary: clinical and financial eligibility.⁵² The DOEA CARES program determines clinical eligibility⁵³ and DCF determines financial eligibility⁵⁴.

Advocate Tip:

It is important for advocates and provider agencies to know that if an individual applying for LTC is currently getting home health service through the Community Care for the Elderly (CCE) program and the individual is released from the wait-list but fails to complete an application or does not meet financial eligibility, and is thus denied, the individual may not be able to get back on CCE right away.

Clinical eligibility

Applicants must have their physician, or other licensed healthcare provider familiar with their needs, complete an AHCA Medical Certification for Medicaid LTC (also referred to as [Form 5000-3008](#))⁵⁵ within 30 days from the date of the wait list notification.⁵⁶

As soon as the ADRC receives a complete and correct Form 5000-

3008, they will contact the CARES office and request a Level of Care (LOC) determination.⁵⁷

The CARES team will then meet with the applicant and complete a 701B comprehensive assessment.⁵⁸ This assessment is administered in a face-to-face meeting by a licensed healthcare provider to ensure the applicant meets the “medical eligibility” for the LTC Waiver.⁵⁹ For those applicants who meet the nursing home level of care requirement, the CARES team assigns the applicant into one of three (3) levels⁶⁰:

Level of care 1: applicants residing in, or who must be placed in, a nursing facility.

Level of care 2: applicants at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, and who require extensive health-related care and services because of mental or physical incapacitation.

Level of care 3: applicants at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, who have a limited need for health-related care and services and are mildly medically or physically incapacitated.

Financial eligibility

Once the Level of Care is determined, the application is forwarded to the Department of Children & Families for completion of eligibility for the LTC waiver.⁶¹ Financial and clinical eligibility determinations can, and should, proceed simultaneously.

The applicant has 35 days from the date of wait list notification to submit the Medicaid application. A Medicaid application submitted through DCF's online ACCESS portal triggers the financial determination.

The ACCESS application asks for the applicant's name, SSN, date of birth, address, phone number as well as income and assets. DCF may also require verification of the applicant's income and assets, e.g., bank statements, pay stubs, and paperwork on asset ownership or recent sales.⁶²

Advocate Tip:

Do not wait until all financial eligibility verification is obtained in order to submit the ACCESS application.

SECTION SIX: WHAT IF APPLICATION IS DENIED OR DELAYED?

INITIAL ASSESSMENT/PRIORITY RANK

Prior to 2020, all individuals who completed the screening process were entitled to written notice from DOEA informing the individual of their waitlist placement, as well as a number of other items including:

- The individual's priority rank;
- Contact information for the ADRCs;
- Instructions for requesting an administrative fair hearing in accordance with Title 42, Code of Federal Regulations (CFR), Section 431, Subpart E⁶³;
- Instructions for requesting a copy of the completed screening tool, which includes the priority score; and
- Instructions for requesting a rescreening. The individual, or their authorized representative, may request a rescreening due to a significant change in condition.⁶⁴

However, in 2020, the Florida Legislature amended section 409.979 of the Florida Statutes in an effort to avoid placing individuals with a "low priority score" on the waitlist. The amendment language stated that the DOEA mandated notice be sent upon completion of screening or rescreening, **"unless the individual has a low priority score."** (emphasis added.)

The Legislature specified that individuals with a low score would,

instead, be informed by aging resource personnel of community resources available to assist them and that they may request a new assessment at any time if they experience a change in circumstances.⁶⁵ The amended statute does not define what a low priority score is. The administrative rule has not yet been amended to reflect the statutory changes as of the date of this January 2021 edition of the Guide.

At the initial rule workshop in September 2020, the Agency spokesperson explained that the rule could take up to 9 months to be developed. For updates on the status of the rule, including any notice of the right to appeal, please check the [portal materials](#) located on FHJP's [consumer video](#) for this program.

AFTER RELEASE FROM WAITING LIST

As discussed, after release from the wait list, individuals must be found to meet both clinical and financial eligibility. If the CARES assessment determines that the clinical eligibility has not been met, and the individual wishes to appeal, an appeal should be filed with both the Medicaid Agency and the Department of Elder Affairs.⁶⁶

If the individual is found ineligible based on the financial assessment done by DCF, DCF will send a final notice of case action, and an appeal should be filed with the DCF hearing office.⁶⁷

SECTION SEVEN: PLAN ENROLLMENT

PICKING A PLAN

An applicant who is found eligible and enrolled in the LTC Waiver must select one of the private managed care plans ("Plans") operating in the region where the applicant resides.

As of the 2018 State Medicaid Managed Care re-procurement process, there are no longer stand-alone long-term care (LTC) plans. Recipients who are eligible for LTC services will choose between either an LTC+ or Comprehensive Plan in their region. Recipients who are eligible for MMA and LTC programs must choose one health plan for all of their services.⁶⁸

The LTC+ Plans provide managed medical assistance (MMA) services and long-term care services to recipients enrolled in the LTC programs. These plans cannot provide services to recipients who are only eligible for regular MMA services. The Comprehensive Plans provide both MMA and LTC services to eligible recipients.⁶⁹

AHCA [publishes a "Snapshot" informational brochure](#) for both LTC managed care and for MMA managed care that sets out the types of plans, the

Regions and the available Plans in each region.⁷⁰

Each of Florida's eleven regions must have at least two managed care plans to choose from for long-term care services. A list of Plans in each region is also available online or at the local ARDC.⁷¹

The enrollee should look at the Choice Counseling website at www.flmedicaidmanagedcare.com; or call 1-877-711-3662 to talk to a choice counselor. An enrollee can also request that a choice counselor meet with him or her at home.

Enrollees who do not voluntarily select a Plan will be auto-assigned by AHCA. The Agency can only assign Plans that meet or exceed performance standards and must take into account several factors including: network capacity; past relationship between the recipient and the provider; and geographic accessibility.⁷²

After selecting a Plan (or being assigned), the Plan will conduct an initial visit. The requirements of the initial visit are enumerated in the Contract between AHCA and the LTC Plans and include explaining the enrollee's rights and responsibilities and finalizing the plan of care.⁷³

SECTION EIGHT: CHANGING PLANS/DISENROLLING

Recipients may request disenrollment at any time via written or oral request to AHCA. Disenrollment for any reason is permitted within the first 120 days after enrollment.⁷⁴

After 120 days, recipients may change plans only for "good cause" or during the annual open enrollment period.

To change their Plan, beneficiaries can speak with a choice counselor at 1-877-711-3662.

"GOOD CAUSE"

Pursuant to the state's current rule, the following reasons constitute good cause for disenrollment and do not require that the enrollee first seek resolution through the plan's internal grievance process:

- A substantiated marketing violation has occurred.
- 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 Plan's panel but is on the panel of another Plan.
- The enrollee needs related services to be performed concurrently, but not all related services are available within the Plan network, or the

- enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
- The Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
 - Immediate risk of permanent damage to the enrollee's health is alleged.

The following also constitute reasons for good cause disenrollment, however the enrollee must first seek resolution with the plan:

- Poor quality of care.
- Lack of access to services covered under the Contract.
- Lack of access to providers experienced in dealing with the enrollee's health care needs.
- Enrollee needs related services concurrently but not all related services are in the Plan's network and either the PCP or another provider determined that receiving the services separately would subject the enrollee to unnecessary risk.⁷⁵

EXEMPTIONS FROM THE LTC WAIVER

The state allows otherwise mandated beneficiaries to request exemption on a case-by-case basis. As with a request for disenrollment (see discussion above), the enrollee should contact the enrollment broker who, in this case, would refer the request to AHCA. If the

issue still cannot be resolved after working with the individual and the available LTC plans in the area, the agency has the ability to instruct the enrollment broker to exempt the individual from enrollment into LTC.⁷⁶

SECTION NINE: CARE PLANNING

INITIAL CONTACT

Once enrolled, the Plan must conduct a face-to-face visit with the enrollee within five business days.⁷⁷

Going over the Handbook

During the initial face-to-face visit, the plan representative provides the enrollee with the Plan's ID card, a provider directory, and an enrollee handbook.⁷⁸

Pursuant to federal regulations the state Medicaid Agency has developed a model enrollee handbook that addresses provisions including:

- the services (also referred to as "benefits") that are provided by the MCO including the amount and length of time that the services are provided;
- how to get the services provided by the MCO, including any procedures needed for obtaining approval of a prescribed service;

- how and where to get any services provided by the State;
- how transportation is provided;
- what emergency services are provided and how to get emergency services;
- information about which providers you can go to, including if/when you can go to a provider who is not in your MCO's network (the word "network" refers to those providers who have signed up with the MCO to provide services to the MCO's enrollees);
- the process for filing grievances when you are unhappy with your MCO;
- the difference between a grievance and an appeal;
- the process for filing an appeal when you don't agree with a decision made by the MCO to deny, reduce or end a service, and the requirement (with some exceptions) that your appeal must first go to the MCO before you appeal to the state Medicaid Agency;
- the right to continued services pending the outcome of an

appeal if services are reduced or terminated;

- the right to a fair hearing with the Florida Medicaid Agency (AHCA) if the MCO does not grant your appeal.⁷⁹

Explaining grievance and appeal

At the initial visit the plan shall review the enrollee's rights and responsibilities, including procedures for filing a grievance, appeal, and or Medicaid Fair Hearing.⁸⁰

Conducting an assessment & developing care plan

Finally, the plan is required to conduct a comprehensive assessment and develop the person-centered care plan of care (discussed below) at the initial meeting.⁸¹

PERSON-CENTERED PLANNING PROCESS

After years of advocacy, CMS finalized rules in 2014 detailing requirements for "person-centered" planning for all HCBS programs.⁸²

"Person-centered" planning means that the process should actually directed by the individual to the "maximum extent possible."⁸³

The process is intended to identify the individual's strengths, capacities, preferences, needs, and desired

measurable outcomes. Enrollees are encouraged to make decisions about service options and identify personal goals. They must also be allowed to invite anyone of his/ her choosing to participate in the process and provide aid as needed or desired.⁸⁴

PERSON-CENTERED PLAN OF CARE

Pursuant to this planning process, Plans are required to develop a person-centered plan of care. ⁸⁵ This is a written document that reflects the clinical and support needs identified through the assessment process, the person-centered goals and objectives, the services and supports (paid and unpaid) that will assist the enrollee in achieving identified goals, and the service providers. ⁸⁶

Additionally, the plan must reflect an enrollee's risk factors and identify measures in place to minimize them, such as individualized backup plans and strategies when needed.⁸⁷

Significantly, the enrollee or enrollee's authorized representative must indicate whether they agree or disagree with each service authorization and review and sign the plan of care at initial development, annual review, and for any changes in services.⁸⁸ In addition, all individuals and providers responsible for its implementation have to sign the care plan. ⁸⁹

In sum, the Plan of Care (or Care Plan) is the critical written document that specifies the services and supports that are to be furnished in order to meet the enrollee's abilities, needs and preferences, e.g., to live in her/his home.⁹⁰

Advocate Tip:

Advocates should ensure that enrollees receive a legible copy of the Care Plan to review before signing.

If an enrollee (or his or her authorized representative) disagrees with any part of the care plan and efforts to resolve with the case manager are not successful, an appeal should be filed. ⁹¹

SUPPLEMENTAL ASSESSMENT

As part of the comprehensive assessment, the Plans are required to complete a written LTC Supplemental Assessment, and all completed forms should be maintained in the client's case file. ⁹² (A sample form is included in the Appendix.)

In addition to including the amount of

time the enrollee can be safely left alone, the assessment must include the following with regard to natural supports:

- The role of each natural support in the enrollee's day-to-day life;
- Each natural support's day-to-day responsibilities, including an evaluation of the support's work, school, and other schedules and responsibilities in addition to caring for the enrollee
- Each natural support's stress and well-being, including any medical limitation or disability the natural support may have that would limit their ability to participate in the care of an enrollee (e.g., lifting restrictions, developmental disorder, bed rest for pregnancy, etc.)
- The willingness of the natural support to participate in the enrollee's care.

ROLE OF CASE MANAGEMENT

Effective case management is a critical part of the LTC Waiver, and Section E of the Contract ("Care Coordination/Case Management) specifies a number of case management duties and time frames for contact with enrollees.⁹³

For example, there must be a face-to-face visit within five (5) days. In addition, the case manager is required to meet with the enrollee, including at least every 90-days (and more frequently if there has been any significant change).⁹⁴

The prior contract had a specific requirement that the Managed Care Plan follow up within seven (7) days after the initial meeting, to ensure that services specified in the plan of care actually started. That requirement is no longer required for all individuals. Rather, the current contract requirement is that the Managed Care Plan start services for all in-home HCBS, for eighty-five percent (85%) of the applicable population within seven (7) days of the initial face-to face visit. The timeframe for "starting services" is measured by the number of days between the day of the initial face-to-face visit and the day on which all approved services are rendered or the

Advocate Tip:

If there is any concern about the sufficiency of services being authorized, a copy of the LTC Supplemental Assessment should be requested from the case manager or the Plan's grievance and appeals coordinator.

first of the initial enrollment month, whichever is later.⁹⁵

The case manager is also responsible for ongoing assistance, including assistance in identifying issues and barriers to the achievement of goals and documenting actions taken to resolve issues as quickly as possible.⁹⁶

REASSESSMENT

Managed Care Plans must conduct an annual reassessment of the enrollee's plan of care to determine whether an enrollee's service needs are being met. Reassessment may be conducted more frequently if the need arises. The Plan shall complete the reassessment using Agency-required forms and the plan-developed LTC Supplemental Assessment form.⁹⁷

PARTICIPANT DIRECTED SERVICES

During the care planning process, enrollees who live in their own home or the home of a family member, can choose to "self-direct" certain waiver services, including adult companion, homemaker, attendant care (private duty nursing), intermittent and skilled nursing, and personal care.

Participants who opt to self-direct these services are then responsible for training workers, setting work

schedules, and submitting timesheets to the plan.⁹⁸ They do not set the pay rate, however.

Florida's 1915(c) waiver application reflected the State's goals for the number of participants selecting "self-direction" as starting at 300 in Year 1 and increasing to 500 for each of the last 3 years of the Waiver.⁹⁹

SECTION TEN: WHAT SERVICES ARE COVERED?

The Florida Legislature has specified the minimum services that LTC Plans must provide. The state contract requires that MCO Plans also include four (4) additional services: adult companion care; attendant nursing care; assistive care and homemaker.¹⁰⁰

A complete list of the services is included in the Appendix, and each service is also briefly described in the LTC Rule.¹⁰¹

Plans must offer all listed services. None of these services has a limit or cap, beyond the requirement that the service be "medically necessary."

SECTION ELEVEN: WHEN MUST COVERED SERVICES BE PROVIDED?

Medical Necessity

In determining if a covered service must be provided to an individual

beneficiary (including the amount, e.g., physical therapy twice a week), the service must be “medically necessary.” There is, however, no definition of “medical necessity” in federal law for adults, including for HCBS services. Rather, the applicable federal regulation simply provides that the service must be sufficient in “amount, duration, and scope to achieve its purpose,”¹⁰² and states have significant flexibility in setting amount, duration and scope standards.¹⁰³

As a result of litigation,¹⁰⁴ Florida’s LTC Waiver now has two standards for determining “medical necessity”—one for HCBS services, and one for “mixed services.”¹⁰⁵ The “mixed service” standard, also applies to all other services covered in the Medicaid program, e.g., hospitalization. Both standards are set forth in the boxes below.

Under the revised rule for “Home and Community-Based, Supportive Services” e.g., adult companion care, adult day care, and homemaker services, “medical necessity” is defined more liberally to acknowledge use of services to meet functional needs and access to the community.

Medical Necessity Definition for HCBS:
<p>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;</p> <p>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;</p> <p>Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.</p> <p>And, one of the following:</p> <p>Enable the enrollee to maintain or regain functional capacity; or</p> <p>Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice. ¹⁰⁶</p>

For "mixed services" (which include all types of nursing care, personal care, and all therapies), the long-standing definition of medical necessity remains applicable.

Florida's General Definition of Medical Necessity, Including for "Mixed Services"¹⁰⁷
<p>"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:</p> <ol style="list-style-type: none"> 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.

Other Coverage Criteria

The LTC Waiver Rule begins with a statement of the overarching goal, i.e., that Plans “provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.”¹⁰⁸

This goal is reflected in specific criteria for coverage, which requires that plans cover services “intended to enable the enrollee to reside in the most appropriate and least restrictive setting,”¹⁰⁹ and in the requirement for a “Supplemental Assessment.”¹¹⁰

As previously discussed, the LTC Supplement Assessment, a key factor in deciding the array of necessary services, must quantify the amount of time an enrollee may safely be left alone and the amount of time a voluntary caregiver is willing/able to provide care. If the enrollee can never be safely left alone and the caregiver works 40 hours a week, an authorization of only 15 hours a week of direct staffing should be challenged.

Accordingly, in addition to the requirements of the LTC Supplemental Assessment, the Contract also prevents the Plans from ignoring the limitations of an enrollee’s natural support system. Specifically, the Contract’s provisions on “Service Authorizations” state that the Plan “shall not deny

authorization for a service solely because a caregiver is at work or is unable to participate in the enrollee’s care because of their own medical, physical or cognitive impairments.”¹¹¹

The Contract also mandates that Plans “shall not deny medically necessary services required for the enrollee to safely remain in the community because of cost.”¹¹²

SECTION TWELVE: WHAT ARE THE STANDARDS FOR ACCESS AND CONTINUED COVERAGE?

TIMELY ACCESS STANDARDS

In order to ensure that plans provide timely access to services, AHCA is required to establish network adequacy standards for the plans, e.g., the number of providers in each county.¹¹³ These requirements, along with the time standards for travel are set forth in the contract between each plan and AHCA.

For most LTC benefits, the AHCA/LTC Plan Contract requires that Plans have at least two providers in each county.¹¹⁴ For those services in which the beneficiary is traveling to the provider, e.g., adult day care or therapy (physical, occupational, respiratory), the travel time maximum is 30 minutes in urban counties and 60 minutes in rural counties.¹¹⁵ Thus, if an individual in Miami Dade County needs physical

therapy three times per week and the travel time to a network provider is an hour, the plan has violated this standard. If the issue cannot be resolved, the recipient has a basis for a good cause disenrollment. See Section, Eight, *supra*.

The Core Contract (which governs both MMA, LTC+, and Comprehensive plans) also requires that plans have sufficient provider contracts to ensure that medically necessary services can be provided with “reasonable promptness” as set forth in the Medicaid Statute.¹¹⁶

The LTC Contract’s network adequacy standards are in Table 1, which requires that there be two providers in each county for most services, and for services that are provided outside of the home, there is a travel time standard of 30 minutes for urban counties and 60 minutes for rural counties.¹¹⁷

CARE COORDINATION AND CONTINUITY

Florida’s LTC contract requires that the MCO have a process for “*immediately reporting any unplanned gaps in service delivery.*” As part of this process, the Plan must prepare a “*Service Gap Contingency and Back-Up Plan*” for enrollees who receive services in their home. A “gap” is the difference between the number of hours required

by the care plan, and the number of hours actually provided.¹¹⁸

The contingency plan must inform the enrollee (or authorized representative) of resources available, including on-call back-up service providers and the “enrollee’s informal support system” in the event of an unforeseeable gap, such as a service provider illness or transportation failure.

The “informal support system” is not the “primary source” for addressing a gap, unless that is the enrollee’s choice. The MCO must ensure that gap services are provided within a three-hour time frame. The MCO must discuss the contingency plan with the enrollee, provide a copy to her/him, and ensure that the plan is updated quarterly.¹¹⁹

LTC plans are also required to include “distinct procedures” in their Utilization Management Program that include “protocols for ensuring that there are not gaps in service authorization for enrollees requiring ongoing services.”¹²⁰

Additionally, in order to help ensure that enrollees do not experience gaps in critical LTC services, plans are required to authorize “maintenance therapies” i.e. treatments that are supportive rather than corrective and that prevent further deterioration¹²¹ for no less than six (6) months. For

services of shorter duration, authorization must be supported by PCP prescription. If no prescription is required, the decision must be “supported by objective evidence-based criteria.” ¹²²

Advocate Tip:

Because physicians may be unaware of this “maintenance therapy” policy and the ability to write prescriptions for at least 6 months for long term care conditions, it can be helpful to provide the physician’s office with a copy of this contract provision.

SECTION THIRTEEN: WHAT IF SERVICES ARE DENIED, DELAYED, REDUCED OR TERMINATED? ¹²³

FILING AN AHCA COMPLAINT

Enrollees who are having trouble accessing services or who are encountering other problems with their LTC Plan can file an official complaint with AHCA. These complaints are reviewed and responded to by trained staff members. In addition, AHCA identifies issues that may indicate systemic problems. While some issues are not amenable to resolution through the complaint portal and may ultimately require a fair hearing, this informal complaint process is not time intensive and may result in a quick resolution.

- A [complaint may be filed either online](#) ¹²⁴ or by speaking with a Medicaid representative by calling toll free 1-877-254-1055.
- 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 be prepared to provide their name and an email address or phone number and provide documentation facilitating communication with AHCA staff, e.g., appointment of representation form, HIPAA release.

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. ¹²⁵ 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.¹²⁶

Filing and resolving a grievance or appeal with the Plan

Grievances and 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.)¹²⁷ The best practice is to file a written request with the Plan. The enrollee handbook must provide the necessary instructions and information for both grievances and appeals.¹²⁸ In addition, any notice of adverse benefit determination should include instructions on how, where, and when to file an appeal. (see discussion below).

The Plan must provide written notice acknowledging the receipt of the grievance or appeal within five business days.¹²⁹

Expedited appeal

Enrollees have the right to an expedited appeal if the standard resolution “could seriously jeopardize the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.”¹³⁰

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

Filing and resolution timeframes both for LTC and MMA plans are as follows:

- Grievance – can be filed at any time and must be decided within 90 days.¹³¹

- Standard appeals - filed orally or in writing within 60 days from the date of the adverse benefit determination notice and must be resolved within 30 days.¹³²
- Expedited appeals - must be resolved within 48 hours after the managed care plan receives the request whether orally or in writing.¹³³ The plan shall also provide oral notice to the enrollee by close of business on the day of resolution, and written notice to the enrollee within two (2) calendar days of the disposition.¹³⁴

Note that 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 enrollee’s best interests.

How to ensure the continuation of benefits?

When a beneficiary’s previously authorized services are terminated, suspended or reduced, she/he has the right to receive continued coverage of the medical services pending the outcome of an appeal and fair hearing. The importance of the right to “aid pending” for low-income individuals was recognized by the United States Supreme Court in the seminal case of *Goldberg v. Kelly*, 397 U.S. 254, 261

(1970). Accordingly, services must be continued if all of the following occur:

- Appeal involves termination, suspension, or reduction of previously authorized service;
- Services were 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.¹³⁵

If the beneficiary is provided with continued coverage of the service and ultimately loses the appeal, the cost of the service can be recouped.¹³⁶

Advocate Tip:

To ensure that services continue, the appeal must be received by the Plan within 10 calendar days of when the notice of adverse benefit determination was sent.

If the appeal is upheld, the fair hearing request must then be filed within 10 calendar days of when the notice of appeal resolution was sent.¹³⁷

The request for continuation of services should always be in writing.

Notice of Appeal Resolution

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

- Results of resolution process and completion date; and if the result was not completely in favor of the enrollee, the notice must include:
 - Information about the right to request a fair hearing and how to do so, and
 - Information on the right to continued benefits pending a final determination.¹³⁸

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 (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;¹³⁹
- Failure of a Plan to act within required timeframes for resolution of grievance or appeal; and
- Denial in whole or in part of the payment for a service.¹⁴⁰

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.

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 (at least in part) in the Plan appeal process.¹⁴¹

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) (described below), the enrollee is "deemed to have exhausted" the plan appeal process and can request a state fair hearing.¹⁴²

WHAT NOTICE REQUIREMENTS APPLY?

The Supreme Court has long recognized the importance of written notices as part of procedural due process.¹⁴³ The federal Medicaid Program regulations which apply to all fair hearings (including for eligibility and non-managed care services) include detailed notice requirements.¹⁴⁴

Additionally, the 2016 federal Medicaid managed care regulations specifically linked the Plan notice requirements to an "adverse benefit

determination" and set forth requirements pertaining to both the content and timing of the notice.¹⁴⁵

The notice must include the following information:

- The ABD that has been made;
- Reason(s) for the ABD (including the right to copies of all documents relevant to the decision free of charge);
- Right to request an appeal, including:
 - Information on exhausting one level of appeal
 - Right to request a state fair hearing;
- Process for appeal;
- Circumstances for an expedited appeal and how to request;
- Right to have benefits continue pending resolution of the appeal, including:
 - How to request continued benefits
 - Circumstances under which enrollee may be required to repay the costs of those services.¹⁴⁶

Additionally, the notice must be accessible to individuals with disabilities or limited English proficiency.¹⁴⁷

Accordingly, AHCA developed template notices that all managed care plans are required to use, including a template notice of an adverse benefit determination made by LTC Plans.¹⁴⁸ See Appendix.

What time standards apply to various notices?

- If the action concerns a termination, suspension, or reduction of a benefit - written notice must be sent 10 days before the date of action.
- If the action concerns a denial of payment - notice must be sent at time of the action-affecting claim.
- If the action concerns a standard service authorization decision that denies or limits services - notice must be sent within 14 days.
- If an expedited service authorization has been requested - notice must be sent within 72 hours.
- If service authorization is not reached within the time frame specified in 42 C.F.R. § 438.210(d), this constitutes a denial on the date that the timeframe expired.

149

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)).

FAIR HEARINGS

Statutory right

Under the federal Medicaid Act, Medicaid beneficiaries have the right to a fair hearing if a claim for medical assistance is denied or not acted on with reasonable promptness.¹⁵⁰

Exhaustion requirement and exceptions

As discussed above, enrollees must first exhaust the Plan's appeal process. Thus, a fair hearing can only be requested after the Plan issues its notice that the adverse benefit determination has been upheld.¹⁵¹

And, as noted above, 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.¹⁵²

Filing and Parties

Medicaid appeals related to services for persons enrolled in a managed care plan are directed to AHCA.¹⁵³ The Plan is the respondent, and "upon request by AHCA, the Agency may be granted party status by the Hearing Officer."¹⁵⁴

Hearing rights

Enrollees have the right to:

- Bring witnesses
- Make legal and factual arguments in person and in writing.
- Present evidence, including new evidence not available at time of decision,
- Review medical records and case file free of charge and in advance.

155

The hearing officer can also obtain, at agency expense, a medical assessment from someone not involved in the original decision.¹⁵⁶

Requesting the case file

The federal regulations and state rules both acknowledge the right of the enrollee to receive, free of charge and a reasonable time before the hearing, a complete copy of the enrollee's case file.¹⁵⁷ 42 CFR 431.242; 59G-1.100(12), F.A.C.

This should include the member notes or case notes, which are records of actions by Plan staff (including the Medical Director) related to the enrollee's care or interactions with the enrollee and providers. The enrollee is also entitled to copies of documents or records relevant to the Plan's adverse benefit determination.

Advocate Tip:

Request a copy of the case file and other relevant documents, in writing when filing the appeal and the fair hearing request. If the Plan fails to respond, file an AHCA complaint or contact the Plan's counsel directly. In the case of a fair hearing, if attempts to resolve with Plan counsel are unsuccessful, a motion to compel can be filed.

Discovery and subpoenas

Florida is one of the only states providing discovery in the 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 purposes of discovery and to prevent delay."¹⁵⁸

Relief

The hearing officer's Final Order should be rendered within 90 days of the requires for fair hearing, unless the time period is waived by the enrollee or extended by the hearing officer. 59G-1.100(18), F.A.C.

Enrollees can also request corrective action retroactive to the date of the error, including payments made by the

enrollee to cover services that were improperly terminated.¹⁵⁹

Advocate Tip:

In addition to requesting the enrollee's case file, helpful discovery can include:

- 1) Requests for production of documents
- 2) Interrogatories
- 3) Requests for Admissions
- 4) Depositions

improvement. Plans submit minutes of these advisory committee meetings, along with the plan's response to identified concerns to AHCA.¹⁶¹

Advocate Tip:

Obtain copies of the advisory committee materials for the LTC Plans in your region and, depending on the information received, discuss appropriate strategic responses with your local ADRC and ICSP staff.

SECTION FOURTEEN: OTHER ADVOCATE/CONSUMER RESOURCES

As part of the LTC Waiver, Florida has established the Independent Consumer Safety Program (ICSP). The ICSP coordinates efforts between the Florida Department of Elder Affairs, the Statewide Long-term Care Ombudsman Program (LTCOP), local ADRCs and AHCA. The ICSP uses staff from LTCOP, DOEA and ADRCs to help enrollees understand and resolve service, coverage, and access complaints.¹⁶⁰

Pursuant to the Contract, Plans are required to have an enrollee advisory committee that meets at least twice a year to consider issues and "obtain periodic feedback" on any identified problems and suggestions for

SECTION FIFTEEN: SUMMARY OF RELEVANT AUTHORITY

The multiple authorities related to Florida's LTC program (and cited in the endnotes) are summarized below. These authorities include federal and state statutes and regulations (rules); contractual provisions between AHCA and the plans, the Waivers Requests and Approval between the state and federal government; and relevant case law, including Settlement Agreements or Orders.

Federal Statutes:

42 U.S.C. § 1396n.

Federal Regulations:

The 2016 federal Medicaid Managed Care regulations at 42 C.F.R. part 438,

which represent a significant regulatory overhaul, increased transparency and modernized Medicaid's managed care programs. Also, for the first time, CMS included specific provision pertaining to LTSS and defined LTSS for the purposes of managed care.¹⁶²

Other relevant federal regulations include 42 C.F.R. § 435.217 (describing individuals who are eligible for home and community –based services), 42 C.F.R. § 440.180 (providing a description of and requirements for HCBS); and 42 C.F.R. § 441.301, *et seq.*, (setting forth the requirements for providing HCBS through a waiver, including the requirements for a “person-centered plan and process.”)

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 (which includes the LTC Waiver). Relevant sections of the Florida Statutes include Fla. Stat. 409.978-409.985.

Florida Administrative Rules:

The state's relevant administrative rules include the Rule pertaining to screening and wait list prioritization and release, Fla. Admin. Code Rule (or F.A.C.) 59G-4.193 and 59G-4.192, incorporating by reference the *Florida Statewide Medicaid Managed Care Long-term Care Program Coverage Policy*, March 2017.

Also relevant are the state rules for plan disenrollment F.A.C. 59G-8.600; the AHCA managed care fair hearings rules described at 59G-1.100, and the DCF income eligibility-related rules at F.A.C. 65A-1.710 *et seq.*

AHCA's Core Contract:

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

- Attachment II: Scope of Service–Core Provisions, February 1, 2019
- Attachment II, Exhibit II-B–Long-term Care (LTC) Program, February 1, 2019

Waiver Applications and Approvals

AHCA's LTC Waiver applications (both original and renewal) set forth in detail all aspects of how HCBS will be provided, and were (will be?) approved by CMS.

Department of Elder Affairs:

The DOEA “*Statewide Medicaid Managed Care Long-term Care Program Enrollment Management System Procedures Manual*,” provides a detailed description of the process by which individuals are released from

the wait list and the eligibility and enrollment process.

APPENDIX

- 1) ABBREVIATIONS
- 2) SERVICES
- 3) CARE PLAN
- 4) SUPPLEMENTAL ASSESSMENT FORM
- 5) TEMPLATE NOTICE

Appendix One: Abbreviations

CMS Network	Children's Medical Services Network
DCF	Department of Children and Families
DOH	Department of Health
DM	Disease Management
CMS	Centers for Medicare and Medicaid Services
FS	Florida Statutes
FFS	Fee-for-Service
HMO	Health Maintenance Organization
LTC	Long-term Care
MMA	Managed Medical Assistance
MCO	Managed Care Organization
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDHP	Prepaid Dental Health Provider
PIHP	Prepaid Inpatient Health Plan
PMHP	Prepaid Mental Health Program
PSN	Provider Services Network
STC	Special Terms and Condition
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
The Act	Social Security Act
The Agency	Agency for Health Care Administration

Appendix Two: Services

LTC Program Minimum Covered Services	
Adult companion care	Intermittent and skilled nursing
Adult day health care	Medical equipment and supplies
Assisted living	Medication administration
Assistive care services	Medication management
Attendant nursing care	Nursing facility
Behavioral management	Nutritional assessment/ risk reduction
Care coordination/ Case management	Personal care
Caregiver training	Personal emergency response system
Home accessibility adaptation	Respite care
Home-delivered meals	Therapies: occupational, physical, respiratory and speech
Homemaker	Transportation, Non-emergency
Hospice	

Appendix Three: Care Plan

What is Included in the Person-Centered Plan of Care?

- ❖ Every enrollee's person-centered plan of care must include:
 - ✓ Enrollee's name and Florida Medicaid identification number
 - ✓ Plan of care effective date
 - ✓ Plan of care review date (at least every 90 days)
 - ✓ The enrollee's personal goals
 - ✓ The enrollee's strengths and preferences
 - ✓ Routine medical services needed, including how much, how often, and who is providing the service(s)
 - ✓ Availability of natural supports to assist in the enrollee's care
 - ✓ Long-term care waiver services, including how much, how often, and who is providing the service(s)
 - ✓ Each service authorization start and end date (if applicable)
 - ✓ A complete list of services and supports to be provided, no matter who is paying
 - ✓ Medication oversight strategies
 - ✓ Current living arrangement and choice of living arrangement
 - ✓ If the enrollee's current living arrangement and choice of living arrangement differ, a goal toward achieving the chosen living arrangement and barriers to be overcome in achieving the goal
 - ✓ Records of enrollees' advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian
 - ✓ If the enrollee resides in an assisted living facility (ALF), services provided by the ALF, including how much and how often the ALF provides those services
 - ✓ Identification of any existing plans of care and service providers and assessment of the adequacy of existing services
 - ✓ Identification of who is responsible for monitoring the plan of care
 - ✓ Case manager's signature
 - ✓ The word-for-word written statement before the enrollee signature field as follows:
 - *"I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended."*, and
 - ✓ Enrollee or enrollee's authorized representative's signature and date

To learn more about the Statewide Medicaid Managed Care Program:

Visit the Agency's SMMC Program website at www.ahca.myflorida.com/SMMC.



Long Term Care Person-Centered Care Plan

Enrollee Personal Profile				
Medicaid ID #		POC Eff. Date		Enrollee Effective Date
First Name		Last Name		MI Date of Birth
Location	▼	Facility Name		Enrollee Phone #
Primary Lang.		Adv. Care Planning	▼	Details
Family & Social History				
Do you have family or friends nearby?				
If yes, how often do you see them?				
What was your profession and/or jobs you worked?				
Do you volunteer or participate in any social groups?				
What is important to the Enrollee?				
Likes & Dislikes (i.e activities, hobbies, foods, etc.)				
What are your special family / cultural traditions?				
Personal Care or Support Preferences				
What do we need to know about the Enrollee?				
Rituals / Routines that are important to the enrollee				
List any communication limitations				
What method of communication do you prefer?				
What are the enrollee's strengths, preferences and self-care capabilities?				
Member modification of HCBS setting:				
Were there any modifications made to the member's HCBS setting since the member's last assessment?		▼ If yes, detail:		
Provide the specific assessed need for the modification of HCBS setting?				
Does the member's current living arrangement differ from their desired living arrangement?		▼ If yes, detail:		
What is the member's goal in achieving the desired living environment?				
What are the barriers to the member's choice of living environment?				
List the people chosen (if any) by the enrollee to participate in their Plan of Care development & reviews:				
Name		Relationship and Contact Phone Number		
		▼		
		▼		
		▼		

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Long Term Care Person-Centered Care Plan

Frequency and Details

Enrollee Name:		Medicaid ID#	
Caregiver/Informal Support Supplemental Assessment			
Who does the enrollee live with?			Other:
Can the enrollee be safely left alone?		If yes, what amount of time can the enrollee be left alone?	Notes:
Are there Caregiver/Informal support available to assist with the enrollee's needs and care?		Notes:	
**Caregiver/Informal Support includes supports that are provided to the enrollee. This can include the enrollee's spouse, family members, neighbors, friends, significant others and church or community volunteer organizations that are willing to support enrollee as part of their Person Centered Plan.			

Supplemental Assessment: List of Caregiver/Informal Support				
Name of Individual/Organization:	Role & Support Provided			
	Services	Frequency, Hours and Details	Services	Frequency, Hours and Details
1)	<input type="checkbox"/> Bathing		<input type="checkbox"/> Heavy Chores	
	<input type="checkbox"/> Dressing		<input type="checkbox"/> Light Housekeeping	
	<input type="checkbox"/> Eating		<input type="checkbox"/> Using Telephone	
	<input type="checkbox"/> Using Bathroom		<input type="checkbox"/> Managing Money	
	<input type="checkbox"/> Transferring		<input type="checkbox"/> Preparing Meals	
	<input type="checkbox"/> Mobility		<input type="checkbox"/> Shopping	
	<input type="checkbox"/> Respite		<input type="checkbox"/> Managing Meds	
	<input type="checkbox"/> Companion		<input type="checkbox"/> Transportation	
	<input type="checkbox"/> Other		Details	
	Stress level			
	Limitations			
	Willingness to Assist			
	Addtl. Responsibilities			
Relationship:				
If Other:				
Name of Individual/Organization:	Role & Support Provided			
	Services	Frequency, Hours and Details	Services	Frequency, Hours and Details
2)	<input type="checkbox"/> Bathing		<input type="checkbox"/> Heavy Chores	
	<input type="checkbox"/> Dressing		<input type="checkbox"/> Light Housekeeping	
	<input type="checkbox"/> Eating		<input type="checkbox"/> Using Telephone	
	<input type="checkbox"/> Using Bathroom		<input type="checkbox"/> Managing Money	
	<input type="checkbox"/> Transferring		<input type="checkbox"/> Preparing Meals	
	<input type="checkbox"/> Mobility		<input type="checkbox"/> Shopping	
	<input type="checkbox"/> Respite		<input type="checkbox"/> Managing Meds	
	<input type="checkbox"/> Companion		<input type="checkbox"/> Transportation	
	<input type="checkbox"/> Other		Details	
	Stress level			
	Limitations			
	Willingness to Assist			
	Addtl. Responsibilities			
Relationship:				
If Other:				
Additional Narrative/Notes				

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Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	
Community Integration: Personal Goal Planning			
<i>A goal should address issues that are identified in the care plan to ensure enrollee is integrated into the community. A goal should be built on strengths and includes steps that the enrollee will take to achieve the goal. Goals are reviewed at each visit to include progress of the goal, potential barriers to progress, any changes needed and if the goal has been met. If enrollee refuses to create a goal the reason must be documented.</i>			
	OBJECTIVE		DATE DEVELOPED
	GOAL		GOAL STATUS
	BARRIER		TIMEFRAME
	INTERVENTION		
GOAL 2	OBJECTIVE		DATE DEVELOPED
	GOAL		GOAL STATUS
	BARRIER		TIMEFRAME
	INTERVENTION		
	OBJECTIVE		DATE DEVELOPED
	GOAL		GOAL STATUS
	BARRIER		TIMEFRAME
	INTERVENTION		
GOAL 4	OBJECTIVE		DATE DEVELOPED
	GOAL		GOAL STATUS
	BARRIER		TIMEFRAME
	INTERVENTION		
	OBJECTIVE		DATE DEVELOPED
	GOAL		GOAL STATUS
	BARRIER		TIMEFRAME
	INTERVENTION		
Self Management Plan			
<i>The enrollee's role in managing the physical and social affects and lifestyle changes associated with their chronic condition or a functional limitation.</i>			
How are you managing your lifestyle changes due to your current condition?			

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Long Term Care Person-Centered Care Plan

Enrollee Name				Medicaid ID#			
LTC Service Plan Details							
Service or Item Type	Service or Item Details	Timeframe (m/d/yy)		Amount	Frequency	Provider	Goal
Case Management ▼		Start Date			▼	Sunshine Health	▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
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		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					



Long Term Care Person-Centered Care Plan

Enrollee Name				Medicaid ID#			
LTC Service Plan Details							
Service or Item Type	Service or Item Details	Timeframe (m/d/yy)		Amount	Frequency	Provider	Goal
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					
▼		Start Date			▼		▼
		End Date					

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Long Term Care Person-Centered Care Plan

Enrollee Name				Medicaid ID#			
Other Existing Care Plans, Services and Service Providers (i.e. PCP, Medicare, Skilled Nursing Care, Specialty Care, Inpatient Admission, Routine Medical, etc.)							
Service Type	Service Detail, Amount and Frequency	Timeframe (m/d/yy)		Payer Source	Provider		
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					

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Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	
Behavioral Health - CBH or Non-CBH - Cenpatco Behavioral Health			
Service Type	Service Details (If Applicable)	Timeframe (m/d/yy)	Amnt / Freq
▼		Start Date	
		End Date	
▼		Start Date	
		End Date	
▼		Start Date	
		End Date	
▼		Start Date	
		End Date	
Medication Oversight Strategies (To be reviewed every 90 days)			
Medication Management	▼	Please explain enrollee's medication strategy in the description below, even if no barrier was identified.	Recommended Strategies or Intervention
Description/Details			
Backup/Contingency Plan - If the service provider does not show the back-up plan will be as follows:			
Back-up Plan		Full Name	Contact number
<input type="checkbox"/> Contact SHP LTC plan		Sunshine Health Plan	1-877-211-1999
<input type="checkbox"/> Contact the current provider directly		Contact Servicing Provider	Contact Servicing Provider
<input type="checkbox"/> Contact designated responsible party:		1	1
<input type="checkbox"/> Caregiver, <input type="checkbox"/> Family, <input type="checkbox"/> Friend to provide care,		2	2
<input type="checkbox"/> Other (specify: _____)		3	3
<i>I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended.</i>			
Reason for Plan Of Care Review (at least every 90 days)		Care Manager Signature	Date Signed
▼		REDACTED	
Individual and/or Entity Responsible for monitoring the Plan of Care		Enrollee or Enrollee's Authorized Representative	Date Signed
		REDACTED	

☐ Signed ☐ Unable to Sign ☐ Refused to Sign ☐ Mailed to POA

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Enrollee Name	Date of Birth	Medicaid ID#
---------------	---------------	--------------

[illegible]

I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended.

Date Signed _____

<div></div>	<div></div>
Enrollee or Enrollee's Authorized Representative	Date Signed
<div></div>	

<input type="checkbox"/> Signed	<input type="checkbox"/> Unable to Sign	<input type="checkbox"/> Refused to Sign	<input type="checkbox"/> Mailed to POA
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46

Appendix D: Supplemental Assessment Form



Caregiver Assessment					
<i>*Please complete the Caregiver Assessment with the member's natural support who are providing care to the member. This excludes paid caregivers. Assessor should conduct one assessment per caregiver.</i>					
Caregiver Demographics					
Caregiver Full Name:					
Caregiver Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Caregiver Date of Birth:		
Caregiver Relationship to individual:	<input type="checkbox"/> Wife <input type="checkbox"/> Son / In-law	<input type="checkbox"/> Husband <input type="checkbox"/> Daughter / In-law	<input type="checkbox"/> Partner <input type="checkbox"/> Other relative	<input type="checkbox"/> Parent <input type="checkbox"/> Other Non-relative	
Caregiver Address:					
City:			State:	Zip:	
Caregiver Primary Phone Number:			Alternative Phone Number:		
Do you currently have anyone to assist you with providing care?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Caregiver Questionnaire					
Do you work outside the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes:	Schedule:	
Do go to school outside the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes:	Schedule:	
Do you have other responsibilities outside the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes:	Please describe other responsibilities:	
				Schedule:	
Do you currently provide care for this client?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, describe the care you are providing and the number of hours for each service provided:					
How many hours per week do you currently spend providing care for the client?					
How long have you been providing care for this client?	<input type="checkbox"/> Less than 6 months <input type="checkbox"/> 1 to 2 years		<input type="checkbox"/> 6 to 12 months <input type="checkbox"/> 2 or more years	<input type="checkbox"/> NA	
Do you need training or assistance in performing caregiving tasks?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
In your opinion, how long can the client be left alone safely?					
Do you experience mental or emotional strain as a result of your responsibility to provide care for the client?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please describe the emotion strain you experience:					
Considering other aspects of your life, please rate the level of difficulty in your:					
Relationship with individual:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Relationship with family:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Relationships with friends:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Physical Health	<input type="checkbox"/> No	<input type="checkbox"/> Little	<input type="checkbox"/> Some	<input type="checkbox"/> Moderate	<input type="checkbox"/> A lot

Member Name: _____

Member ID Number: _____

	Difficulty	Difficulty	Difficulty	Difficulty	Difficulty
Finances:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Functional Abilities:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Employment:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Time for yourself to do the things you enjoy:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Other responsibilities such as caring for children / other family members, going to school, religious or social activities, etc.:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Are you willing to provide or continue to provide care or services to the client?	<input type="checkbox"/> Willing to provide More Care	<input type="checkbox"/> Willing to provide Same Care	<input type="checkbox"/> Willing to provide Less Care	<input type="checkbox"/> Unable to provide any care	
How confident are you that you will have the ability to provide or continue to provide care?	<input type="checkbox"/> Very confident		<input type="checkbox"/> Somewhat confident	<input type="checkbox"/> Not very confident	
If not confident, what is the main reason you may be unable to continue to provide care?					
How many hours per week do you think you could reasonable provide going forward?					
Assessor Information					
Is the caregiver in crisis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, check all that apply:		<input type="checkbox"/> Financial	<input type="checkbox"/> Emotional <input type="checkbox"/> Physical
Assessor Name:			Date of Caregiver Assessment:		

Appendix E: Template Notice

PLAN ID: XXXXXXXXXXXXXXXXXXXXX

<<ENROLLEE>> and/or

<<LEGAL REPRESENTATIVE>>

<<STREET ADDRESS>>

<<CITY, STATE ZIP>>

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear <<ENROLLEE/LEGAL REPRESENTATIVE>>:

<<LTC PLAN>> has reviewed your request for <<SERVICE and AMOUNT>>, which we received on <<DATE>>. After our review, this service has been:

<<PARTIALLY DENIED, DENIED, TERMINATED, SUSPENDED, REDUCED>> as of
<<EFFECTIVE DATE OF ADVERSE BENEFIT DETERMINATION>>

We made our decision because:

(Check all boxes that apply)

☐ We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: *(See Rule)*

- ☐ Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR
- ☐ Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:
 - 1. 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;
 - 2. 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
 - 3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

and one of the following:

- 1. Enable the enrollee to maintain or regain functional capacity; or
- 2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

☐ The requested **service is not a covered benefit**.

☐ **Other authority** <<explain and cite authority>>

The facts that we used to make our decision are: <<explain>>

SAMPLE This determination of the Medical Director has been made based on medical necessity (as defined by Florida law – specifically see checked box above) and reflects the application of the Plan's approved review criteria and guidelines.

Clinical rationale: for clinician to write – see example for detail below – it would be different for each type of clinician

Example from eQHealth

Clinical Rationale for Decision: The patient is a ____ old with a history of gastroesophageal reflux disease and apnea. The patient is on an apnea monitor. Over the past month, the patient had four reported incidences on the monitor. No skilled interventions were required for these reported events. The patient is on oral ____ every 4 hours and requires positioning after meals. The patient is on two scheduled medications and as needed nebulizer treatments. The patient is currently attending ____ during the day. The request is for skilled nursing for 12 hours per day 7 days per week. The patient lives with his ____ and _____. The clinical information provided does not support the medical necessity of the requested services. The patient does not have any ongoing skilled interventions which would support skilled nursing. Additionally, the patient does not require nighttime monitoring by a skilled nurse.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge.

You may request these documents by contacting: <<Plan supplied contact information>>

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from <<LTC PLAN>>. When you ask for a plan appeal, <<MANAGED CARE PLAN>> has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 60 days* of the date of this letter. (If you wish to continue your services until a final decision is made on your appeal,

we must receive your request sooner. See the “How to Ask for your Services to Continue” section below for details.) Here is where to call or send your request:

<<MCO>>

<<MAILING ADDRESS>>

<<PHONE>>

<<FAX>>

<<EMAIL>>

Your written request for a plan appeal must include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where we can reach you or your legal representative

You may also include the following information if you have it:

- Why you think we should change the decision
- Any medical information to support the request
- Who you would like to help with your plan appeal

Within five days of getting your plan appeal request, we will tell you in writing that we got your plan appeal request unless you ask for an expedited (fast) plan appeal. We will give you an answer to your plan appeal within 30 days of you asking for a plan appeal.

How to Ask for an Expedited (Fast) Plan Appeal if Your Health is At Risk:

You can ask for an “expedited plan appeal” if you think that waiting 30 days for a plan appeal decision resolution could put your life, health, or your ability to attain, maintain, or regain maximum function in danger. You can call or write us (see above), but you need to make sure that you ask us to *expedite* the plan appeal. We may not agree that your plan appeal needs to be expedited, but you will be told of this decision. We will still process your plan appeal under normal time frames. If we do need to expedite your plan appeal, you will get our plan appeal resolution within 48 hours after we receive your plan appeal request. This is true whether you asked for the plan appeal by phone or in writing.

How to Ask for your Services to Continue:

If you are now getting the service that is scheduled to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made in a plan appeal and, if requested, fair hearing. If your services are continued, there will be no change in your services until a final decision is made in your plan appeal and, if requested, fair hearing.

If your services are continued and our decision is upheld in a plan appeal or fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during the plan appeal, you **MUST** file your plan appeal **AND** ask to continue your services within this time frame:

File a request for your services to continue with <<LTC PLAN>> no later than 10 days after this letter was mailed OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, whichever is later. You can ask for a plan appeal by phone. If you do this, you must then ***also*** make a request in writing. **Be sure to tell us if you want your services to continue.**

To have your services continue during the fair hearing, you **MUST** file your fair hearing request **AND** ask for continued services within this time frame:

If you were receiving services during your plan appeal, you can file the request for your services to continue with the Agency for Health Care Administration (Agency) **no later than 10 days** from the date on your notice of plan appeal resolution OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, ***whichever is later***.

What to Do if You Disagree with the Plan Appeal Decision

You will receive the result of the plan appeal process in a notice of plan appeal resolution (notice) that outlines the outcome of the plan appeal. If you still do not agree with our decision, or if you do not receive your notice on time, you can ask for a fair hearing.

How to Ask for a Fair Hearing:

When you ask for a Medicaid fair hearing, a hearing officer who works for the state reviews the decision that was made. You may ask for a fair hearing any time up to 120 days after you get our notice of plan appeal resolution. **You must finish your plan appeal process first.**

You may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration

Medicaid Hearing Unit

P.O. Box 60127

Ft. Myers, FL 33906

(877) 254-1055 (*toll-free*)

239-338-2642 (*fax*)

MedicaidHearingUnit@ahca.myflorida.com

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request.

If you have questions, call us at <<PHONE>> or <<TTY NUMBER>>. For more information on your rights, review the Grievance and Appeal section in your Member Handbook. It can be found online at: <<WEB ADDRESS>>.

Notice of Nondiscrimination

<< INSERT NONDISCRIMINATION LANGUAGE>>

Sincerely,

<<NAME>>

<<Medical Director or title of other professional who made the adverse benefit determination in accordance with Attachment II, Section VII.G.4 of the SMMC contract>>

¹ Reinhard et al, *Picking Up The Pace of Change: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, Long-Term Services and Supports State Scorecard 2017 Edition, at 5. LTSS scorecard (LTSS State Scorecard: 2017 Ed. AARP et al.) at 5 (about 52% of will at some point develop a severe disability that will require LTSS.)

² Fla. Stat § 409.979 (1); *see also* § 1915(c) of the Social Security Act authorizing state Medicaid programs to provide home and community-based services, including services that are not strictly medical in nature, for individuals who would otherwise need care in a nursing home or other institution, are authorized under. 42 U.S.C. § 1396n(c); 42 C.F.R. § 440.180(b).

³ Fla. Stat § 409.979 (3).

⁴ § 1915(c) of the Social Security Act, 42 U.S.C. §1396n(c).

⁵ Fla. Stat. §409.979(1)(a)1.

⁶ 42 U.S.C. § 1396a(a)(1), (10)(B),(10)(C)(i).

⁷ 42 U.S.C. § 1396a(a)(23).

⁸ 42 U.S.C. §1396n(c)(9).

⁹ Nursing home services, unlike HCBS, are mandatory under federal and state Medicaid statute. 42 U.S.C. § 1396a(a)(10)(A)(i) Fla. Stat. §409.905(8).

¹⁰ Fla. Stat. §409.964.

¹¹ *Id.*

¹²[https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915\(b\)_LTC_Waiver.pdf](https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915(b)_LTC_Waiver.pdf) at 92.

¹³

[https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915\(c\)_LTC_Waiver.pdf](https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915(c)_LTC_Waiver.pdf).

¹⁴

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Approval_Letter_2016-12-19.pdf CMS December 19, 2016 approval letter.

¹⁵ The Application for 1915(c) Home and Community –Based Services Waiver (an amendment of the 12/28/16 Waiver effective December 2020(increased the maximum number of participants served at any point to 76,000 in Year 5. The amendment also allowed for the unduplicated number of participants to range from 68,709 in Year 1 to 98,327 in Year 5.)

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915c_Waiver_Amendment_12-17-2020.pdf at page 31-32 of 272

¹⁶ *Id.*

¹⁷ *Id.* at 32.

¹⁸ Unlike the Section 1115 Waiver authorizing Florida to implement a statewide mandatory managed care system for Medicaid's general medical services, CMS' approval of the managed care program for long-term services and supports does not contain any specific agreement between CMS and the State specifying how the state is required to administer the waiver. *See* <https://www.floridahealthjustice.org/medicaid-guide.html> at 24, re August 3, 2017, CMS Special Terms and Conditions (STCs) pertaining to the 1115 Waiver's approval period from August 2017 through June 2022.

¹⁹ 42 U.S.C. §1396a(a)(5); 42 C.F.R. § 431.10.

²⁰ Fla. Stat. § 409.901(2).

²¹ *See* Fla. Stat. § 409.979 (3) for description of DOEA responsibilities in the LTC Waiver; *see also*

[https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915\(b\)_LTC_Waiver.pdf](https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915(b)_LTC_Waiver.pdf) at 4.

²² Fla. Stat. § 409.902(1).

²³ Pursuant to Fla. Stat. § 409.979(2)(a), 150 individuals from the Adults with Cystic Fibrosis Waiver transitioned, 468 individuals from the Traumatic Brain and Spinal Cord Injury Waiver transitioned, and approximately 1,100 individuals from the Project AIDS Care Waiver were transitioned into the LTC Waiver. *see also*

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/1915c_Waiver_Amendment_12-17-2020.pdf at 3.

(Note, not all individuals in the PAC waiver were transitioned in the LTC. Only those receiving HCBS who met a nursing facility level of care were transitioned into the LTC. Others maintained Medicaid eligibility through an amendment to the 1115 Managed Medical Assistance Waiver that established financial and non-financial eligibility criteria.)

²⁴ Fla. Stat. § 409.979(2)(a); *see also*

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Current_Approved_LTC_Waiver_Document_Effective_12_1_17.pdf at 10.

²⁵ “Who Can Get PACE?” <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/pace#>

²⁶ “PACE” <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/pace>.

²⁷ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 14-16.

²⁸ Fla. Stat. § 409.985 (3); Fla. Admin. Code R. 59G-4.192, incorporating by reference the *Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy*, March 2017, (hereafter the LTC Waiver Rule), March 2017 at 3.

²⁹ Fla. Stat. § 409.985 (1)(3). The Medicaid Agency operates the CARES program through an inter-agency agreement with the Department of Elder Affairs. § 409.985 (2).

³⁰ Fla. Stat. § 409.902(1); Fla. Admin Code R. 65A-1.712(1)(f); Fla. Admin Code R. 65A-1.713(1)(e).

³¹ Fla. Admin Code R. 65A-1.716(5)(b), *see also*:
https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf

³² Fla. Admin. Code R. 65A-1.713(1)(e) noting that establishment to an income trust for purposes of qualifying for HCBS must comply with the requirements set forth in Fla. Admin Code R. 65A-1.702(15).

³³ Fla. Admin Code R. 65A-1.716(5)(a); *see also*
https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf

³⁴ <http://elderaffairs.state.fl.us/doea/arc.php>

³⁵
<http://elderaffairs.state.fl.us/doea/notices/Mar02/2020Chapter2IntakeScreeningPrioritizationAssessment.pdf>

³⁶ The 701A Condensed Assessment, incorporated by reference in Fla. Admin. Code r. 58A-1.010 is based upon the 701B Comprehensive Assessment. Local programs complete the 701A assessment tool as an eligibility requirement prior to rendering a service that is funded by the local ADRC. It is administered face-to-face to non-case managed clients in local OAA (Older Americans Act) programs, *see*, Department of Elder Affairs, Assessment Forms, Instructions, and Training; (http://elderaffairs.state.fl.us/doea/reports_pubs_afst.php). Currently, the 701A assessment tool does not have an accompanying instructional tool.

However, the 701D Instructions, which serve as a guide for completing the 701B assessment tool, can be used as a guide as the 701A is based on the 701B. Department of Elder Affairs, 701D Instructions.

(http://elderaffairs.state.fl.us/doea/forms/701D_Assessment_Instructions.pdf).

³⁷ http://elderaffairs.state.fl.us/doea/forms/701S_Screening_Form.pdf

³⁸ Fla. Stat. § 409.979(3)(a), Fla. Admin. Code R. 59G-4.193(3)(a).

³⁹ See LTC Waiver Rule at 1-2; Sections 1.3.1; 1.3.9 defining ADLs as including, e.g. bathing, dressing, eating, toileting transferring maintaining continence and IADLs as including those activities necessary to allowing the individual to function independently, e.g. grocery shopping, laundry, light paperwork, money management.

⁴⁰ *Id.*, see also <http://elderaffairs.state.fl.us/doea/notices/Jan13/12-17%20FINAL%20Priority%20Score%20Training.pptx>

⁴¹ It may be useful to review the training power point provided to interviewers. See http://elderaffairs.state.fl.us/doea/public_training/SMMCLTC/701S%20Training%20-%20Storyline%20output/story_html5.html.

⁴² It may be useful to review the 701D form which provides standardized instructions for assessors completing the 701B. See http://elderaffairs.state.fl.us/doea/forms/701D_Assessment_Instructions.pdf

⁴³ Fla. Admin. Code R. 59G-4.193(3)

⁴⁴ http://elderaffairs.state.fl.us/doea/SMMCLTC/2014_Priority_Score_Calculation.pdf

⁴⁵ Fla. Admin. Code Rule 59G-4.193(3)(b).

⁴⁶ Fla. Stat. § 409.979(f).

⁴⁷ Fla. Admin. Code R. 59G-4.193(2)(d).

⁴⁸ Fla. Stat. § 409.979(3)(d), see also the DOEA “*Statewide Medicaid Managed Care Long-term Care Program Enrollment Management System Procedures Manual*” for a detailed description of the process by which individuals are released from the wait list and the eligibility and enrollment process. The most recent Manual on-line is from 2014. <http://elderaffairs.state.fl.us/doea/notices/Jan14/SMMC%20LTC%20EMS%20Procedures%20March%202014.pdf>. Pursuant to a 2020 public records request, the authors of this Guide were provided with the updated and expanded Enrollment Management System (EMS) Procedures Manual currently in use dated September 2018. This Manual is available on the Florida Health Justice Website

https://www.floridahealthjustice.org/uploads/1/1/5/5/115598329/smmc_ltc_ems_procedures_09.06.18_update.pdf. (Hereafter “EMS Manual”)

⁴⁹ *Id.* at 14.

⁵⁰ *Id.* at 15.

⁵¹ *Id.* at 14-17.

⁵² Fla. Admin. Code R. 59G-4.1939(g), *see also*, EMS Manual at 15-24.

⁵³ Fla. Stat. § 409.985, Fla. Admin. Code R. 59G-4.180, 59G-4.290.

⁵⁴ Fla. Stat. § 409.902(2), Fla. Admin. Code R. 65A-1.205.

⁵⁵ Fla. Admin. Code R. 59G-1.045(4), *see also*,
<http://elderaffairs.state.fl.us/doea/cares/Medical Cert for Long Term Care 5000 3008.pdf>.

⁵⁶ EMS Manual at 19.

⁵⁷ *Id.* at 21.

⁵⁸ Fla. Admin. Code R. 59G-4.193(g); Fla. Admin. Code R. 58A-(1)(b).

⁵⁹ LTC Waiver Rule at Section 1.3.5; *see also*,
http://elderaffairs.state.fl.us/doea/forms/701B_Comprehensive_Assessment.pdf

⁶⁰ Fla. Stat. § 409.985(3).

⁶¹ EMS Manual at 23.

⁶² <https://dcf-access.dcf.state.fl.us/access/scrflhomepage.do?performAction=changeLocale&language=english> *See also*, Florida Department of Children and Families, Program Policy Manual <https://www.myflfamilies.com/service-programs/access/program-policy-manual.shtml> at §§ 1640.0000, 1840.0000.

⁶³ Fla. Admin. Code Rule 59G-4.193(3)(d)3. Pursuant to the current administrative rule, instructions for requesting a hearing should conform with the Federal Medicaid regulation governing fair hearings for applicants and recipients.

⁶⁴ Fla. Admin. Code Rule 59G-4.193(3)(d).

⁶⁵ Ch. 2020-46, §1, Laws of Fla. (amending Fla. Stat. § 409.979 (2019)).

⁶⁶ There is no current authority in either state statute or rule (or in the EMS Manual) addressing notice and right to appeal if an individual released from the wait list is determined not to meet the requisite

level of care. Thus, it would be prudent to appeal to both DOEA and the Agency for Health care. The authors have requested clarification.

⁶⁷ Fla. Stat. 409.902(1); Appeal Hearings Section, [1317 Winewood Blvd. Building 5, Room 255](mailto:appeal.hearings@myflfamilies.com), Tallahassee, FL 32399-0700, Phone 850-488-1429 | Fax 850-487-0662, appeal.hearings@myflfamilies.com.

⁶⁸

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Overview_12042018.pdf at 35; see also https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf.

⁶⁹

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Overview_12042018.pdf at 37.

⁷⁰ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf; see also, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Overview_12042018.pdf at 26 and 27.

⁷¹ See link for list of ADRCs and contact information:

<http://elderaffairs.state.fl.us/doea/arc.php>

⁷² Fl. Stat. § 409.984(1)(2).

⁷³ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 14-15.

⁷⁴ The Florida Medicaid Agency (AHCA) has confirmed that beneficiaries are allowed 120 days to disenroll for any reason, notwithstanding that the Florida statute and federal regulation specify a 90 day period. (email confirmation from AHCA available from Florida Health Justice Project.)

⁷⁵ Fla. Admin. Code R. 59G-8.600(b). See also Fla. Stat. § 409.969(2), providing that “the Agency may require a recipient to use the plan’s grievance process before the agency’s determination of good cause...” the Agency has implemented this requirement in the rule, see Fla. Admin. Code R. 59G-8.600(b). see also, [https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915\(b\)_LTC_Waiver.pdf](https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915(b)_LTC_Waiver.pdf) at 33; 42 C.F.R. § 438.56. Notably, Florida’s Medicaid Agency provides for a larger time frame (120 days) than the amount required under federal law (90 days).

[https://ahca.myflorida.com/medicaid/Policy and Quality/Policy/federal authorities/federal waivers/docs/Final 1915\(b\) LTC Waiver.pdf](https://ahca.myflorida.com/medicaid/Policy%20and%20Quality/Policy/federal%20authorities/federal%20waivers/docs/Final%201915(b)%20LTC%20Waiver.pdf) at 32-33. at 32-33.

⁷⁷ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 15.

⁷⁸ See 42 C.F.R. 438.10(g) requiring that the handbook explain key elements of how

⁷⁹ 42 C.F.R. 438.10(g); See also *Enrollee Handbook Template for Enrollees with MMA and LTC Benefits* https://ahca.myflorida.com/Medicaid/statewide_mc/app_contract_materials.shtml

⁸⁰ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 15.

⁸¹ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 17-18.

⁸² See generally, Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Bases Services (HCBS), 79 Fed. Reg. 2948, 303-31 (Jan 16, 2014)(codified at 42 C.F.R. § 441.301(c)).

⁸³ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 17.

⁸⁴ 42 C.F.R. § 441.301(c)(1); https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 17.

⁸⁵ 42 C.F.R. § 441.301(c)(2).

⁸⁶ 42 C.F.R. § 441.301(c)(2); https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 18-19.; see also, https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf

⁸⁷ 42 CFR § 441.301(C)(2)(vi).

⁸⁸ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at Sec. VI(E)(5)(b)(4), 19; see also 42 C.F.R. § 441.301(c)(2)(ix); 42 C.F.R. 441.301(c)(3).

⁸⁹ 42 C.F.R. § 441.301(c)(2)(ix); The requirement that providers responsible for implementing care plan sign the plan is included in the federal regulation. This expansive requirement does not appear in the current Contract. A prior contract (from February 1,

2018) required that the primary care provider be sent a copy of the plan of care and advised in writing who to contact with questions regarding adequacy. The current contract's section on plan of care no longer includes that requirement.

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf, Sec. VI(E)(5)(b)

⁹⁰ 42 CFR § 441.301(C)(2); *see also*

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 18-19.

⁹¹ Language regarding the right to written notice and appeal of the Plan of Care per se is not entirely consistent *vis a viz* the Rule, the current Contract and the 1915c application. The Contract requires that the Plan of Care include indication by the enrollee or the enrollee's representative that they agree or disagree with each service authorization and review and sign the plan. Section VI.E.5.b.(4).

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 19. The LTC Rule requires that the Plan of Care be reviewed with the enrollee and include a statement preceding the enrollee's signature attesting that the plan of care has been discussed with and agreed to by the enrollee, and the enrollee understands he/she has the right to request a Fair Hearing *if services are denied or reduced*,". The Florida 1915(c) Waiver application unambiguously provides for the right to written notice and an appeal if the enrollee wishes to challenge any part of the care plan. ***"If the enrollee disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the participant with a written notice of action that explains the enrollee's right to file an appeal. The case manager assists the enrollee with filing for an appeal."***

[https://ahca.myflorida.com/medicaid/Policy and Quality/Policy/federal authorities/federal waivers/docs/Current Approved LTC Waiver Document Effective 12 1 17.pdf](https://ahca.myflorida.com/medicaid/Policy%20and%20Quality/Policy/federal%20authorities/federal%20waivers/docs/Current%20Approved%20LTC%20Waiver%20Document%20Effective%2012%201%2017.pdf) at 149.

⁹² LTC Waiver Rule at 8, Section 6.2.1.

⁹³ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 14-23. *See also* 1915(c) Waiver Application at 151-5; C.F.R. . § 438.208.

⁹⁴ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 21.

⁹⁵ It is important to note that there is still liability for failing to follow up within seven (7) days in Section XIV, Liquidated Damages.

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 72, No. 9.

⁹⁶ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 21,

⁹⁷ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 17; LTC Waiver Rule at 8, Sec. 6.2.1. *See* Appendix D for sample Supplemental Assessment Form. Note: the attached sample is not from a current plan; the authors are in the process of obtaining a sample form from a current plan.

⁹⁸ Application for 1915(c) HCBS Waiver: FL.0962.R01.00 - Jul 01, 2016 pg. 174

⁹⁹ Application for 1915(c) HCBS Waiver: FL.0962.R01.00 - Jul 01, 2016 pg. 181.

¹⁰⁰ Fla. Stat. § 409.98,
https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 8-9. *See also* Snapshot, Appendix B.

¹⁰¹ LTC Waiver Rule at 4-8.

¹⁰² 42 C.F.R. § 440.230.

¹⁰³ *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.)

¹⁰⁴ Florida changed the definition rule for LTC supportive services following settlement of a statewide class action, *Parrales et al. v. Dudek/Senior*, N.D. F. 4:15-cv-424-RH/CAS, brought on behalf Plaintiffs enrolled in the LTC waiver who were unable to obtain necessary services.

¹⁰⁵ The LTC Waiver Rule defines mixed services as “services that covered in both the LTC and the Managed Medical Assistance programs. When covered by both the enrollee’s LTC and MMA plans, such services are the responsibility of the LTC plan.” LTC Waiver Rule at Section 1.3.15.

¹⁰⁶ Fla. Admin. Code R. 59G-4.192, incorporating by reference the “Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy, March 2017, (hereafter the LTC Waiver Rule) at Section 1.3.5.

¹⁰⁷ Fla. Admin. Code R. 59G-1.010, *Definitions Policy*, section 2.83 at 7.

¹⁰⁸ LTC Waiver Rule at 1, § 1.1.

¹⁰⁹ LTC Waiver Rule at 4, §§ 4.2.

¹¹⁰ LTC Waiver Rule at 8, § 6.2.1.

¹¹¹ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 24, §§ G. 2. ,F.

¹¹² *Id.*

¹¹³ Fla. Stat. §§ 409.982(4); *see also* 42 C.F.R. §438.68.

¹¹⁴ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 32-34.

¹¹⁵ https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 32-35. *See also*, 42 C.F.R. §438.206; [http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915\(b\)_LTC_Waiver.pdf](http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915(b)_LTC_Waiver.pdf) at 16.

¹¹⁶ The Core Contract cites to the “reasonable promptness” requirement in the federal Medicaid statute at 42 U.S.C. 1396a(a)(8). https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 91. However, in contrast to the time standards for determining eligibility (45 days for eligibility not dependent upon disability determination; 90 days for determination based on disability), 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. *See, e.g. Doe 1-3 ex rel. Doe Sr. 1-13 v. Chiles*, 136 F. 3d 709(11th Circ. 1998) (finding reasonable promptness provision at 1396a(a)(8) enforceable and requiring state to establish reasonable waiting list time, not to exceed 90 days for individuals eligible for IXCF/MR care.)

¹¹⁷ The Current Contract requires that enrollees receive medically necessary services “with reasonable promptness (within the meaning of that term as set forth in 42 U.S.C. §1396a(a)(8)).” https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 91. The Prior Contract’s Network Adequacy Standards (Section VI) required that plans “provide authorized HCBS within the timeframes specified in Section V, Covered Services.” In turn, Section V required plans to ensure services are started within fourteen (14) days after the plan of care is developed and that the plan of care is developed at the initial meeting (within 5 days of enrollment); thus, in the prior contract there was a requirement that enrollees should begin receiving medically necessary services within 19 days of enrollment.

¹¹⁸ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 12-13, *see also* 2016 federal regulations which were broadened to ensure that enrollees have access to ongoing sources of all appropriate care, including LTSS. 42 C.F.R. 438.208 (b).

¹¹⁹ *Id.*

¹²⁰ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 24-25

¹²¹ LTC Waiver Rule at 2, Section 1.3.12.

¹²² https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 24.

¹²³ Grievance, appeals, and fair hearings are the same for LTC as for the state's managed medical assistance (MMA) plans,
https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 74-82, Section VII.

¹²⁴ <https://ahca.myflorida.com/Medicaid/complaints/>.

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

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

¹²⁷ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 77; *see also* 42 C.F.R. § 438.406(b)(3).

¹²⁸ 42 C.F.R. § 438.406.

¹²⁹ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 77; *see also*, 42 C.F.R. § 438.406 (b)(1).

¹³⁰ 42 C.F.R. § 438.410;
https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 79.

¹³¹ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 75.

¹³² *Id.* at 77-78 .

¹³³ *Id.* at 79.

¹³⁴ *Id.*

¹³⁵ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 77, Section VII.F.1.f.; *see also* Section VII.J.10. at 80.

¹³⁶ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment II Core Contract Provisions 2020-07-01.pdf at 81, Section VII.J.12.; *see also* 42 C.F.R. § 438.420(d).

¹³⁷ 42 CFR 438.420(c).

¹³⁸ 42 C.F.R. § 438.408(e); *see also* Core Contract https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment II Core Contract Provisions 2020-07-01.pdf at 76.

¹³⁹ However, neither the AHCA contract with LTC plans nor the 1915(b) waiver request specify a time standard for obtaining a service (appointment).

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

¹⁴¹ 42 C.F.R. § 438.402; Fla. Admin. Code R. 59G-1.100 (3)(b)1; https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment II Core Contract Provisions 2020-07-01.pdf at 80, Section VII.J.2.

¹⁴² 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.

¹⁴³ *Goldberg v. Kelly*, 397 U.S. 254 (1970).

¹⁴⁴ 42 C.F.R. § 431.210 *et seq.*

¹⁴⁵ 42 C.F.R. § 438.404.

¹⁴⁶ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment II Core Contract Provisions 2020-07-01.pdf at 76, Section VII.E.1, requires that the plan use the template notice provided by AHCA. *See* Appendix for Template Notice.

¹⁴⁷ 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.

¹⁴⁸ Statewide Medicaid Managed Care (SMMC) Policy Transmittal, 2.24.17, Policy Transmittal: 17:08 at http://ahca.myflorida.com/medicaid/statewide_mc/smmc_plan_comunications_archive.shtml. A copy of the template LTC notice of adverse benefit determination is in the Appendix. *See also* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment II Core Contract Provisions 2020-07-01.pdf at 76.

¹⁴⁹ 42 C.F.R. § 438.404(c).

¹⁵⁰ 42 U.S.C. § 1396a(a)(3).

¹⁵¹ 42 C.F.R. § 438.402; Fla. Admin. Code R. 59G-1.100 (3)(b)1;
https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 80, Section VII.J.

¹⁵² 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.

¹⁵³ Fla. Stat. § 409.285(2).

¹⁵⁴ Fla. Admin. Code R. 59G-1.100 (4).

¹⁵⁵ 42 C.F.R. § 438.406(b)(4)(5); *compare*
https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Attachment_II_Core_Contract_Provisions_2020-07-01.pdf at 80-82.

¹⁵⁶ 42 CFR 431.240(b); Fla. Admin. Code R 59G-1.100(17)(n),

¹⁵⁷ 42 CFR 431.242; Fla. Admin. Code R 59G-1.100(12),

¹⁵⁸ Fla. Admin. Code R. 59G-1.100 (13).

¹⁵⁹ 42 C.F.R. § 431.246; Rule 59G-1.100(18)(f). *See also, See Kurnik v. Department of Health and Rehabilitative Services*, 661 So. 2d 914 (Fla. Dist. Ct. App. 1995) *French v. Dep't of Children & Families*, 920 So. 2d 671 (Fla. 1st DCA 2006).

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[https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915\(b\)_LTC_Waiver.pdf](https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915(b)_LTC_Waiver.pdf) at 45.

¹⁶¹ https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_B_LTC_2020-07-01.pdf at 37, *see also* 42 C.F.R. 438.110(a).

¹⁶² <http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care>.