RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

August 30, 2024

Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2024-10

Applicable to the **2018-2024 SMMC contract benefits** for:

- ☒ Managed Medical Assistance (MMA) and MMA Specialty
- ☒ Long-Term Care (LTC)
- ☒ Dental

Re: Revised Notices of Adverse Benefit Determination Templates Effective October 1, 2024

Managed care plans must utilize Agency-approved notice templates for all adverse benefit determinations and plan appeal resolutions issued to enrollees. (MMA & LTC: Attachment II, Section VII.E.1. and Dental: Attachment II, Section VII.E.1). The purpose of this policy transmittal is to provide managed care plans with revised Agency-approved templates for the Notice of Adverse Benefit Determination (NABD).

Effective October 1, 2024, the Managed Care Plans must use the new NABD templates attached to this policy transmittal. Managed Care Plans may only modify the attached templates for plan letterhead and header information, to appropriately fill dynamic text, and to incorporate additional fields that provide specific information in relation to the notice about the enrollee, the provider, or the service authorization. The plan must submit sample completed NABD templates to their Agency Contract Manager for review and approval by September 13, 2024.

All completed NABD forms **must** include text under the “facts that we used to make our decision” portion of the form and **must** include a detailed description of the clinical rationale for the decision. The purpose of this information is to ensure enrollees understand the managed care plans’ reason for the adverse benefit determination.

The managed care plan must adhere to the federal Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) requirement as defined by 42 U.S.C. § 1396d(r)(5) and 42 CFR 440.40(b) or its successive regulation. Nothing in the contract waives the EPSDT requirements of 42 U.S.C. § 1396d(r)(5). As such, in accordance with § 1396d(r) and all binding federal precedents interpreting it, the Managed Care Plan must, for Medicaid eligible children under the age of twenty-one (21) years, pay for any “other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this Section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” (42 U.S.C. 1396d(r)(5)) The Managed Care Plan shall not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21) years. The Managed Care Plan shall develop a special services process to authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary. (MMA & LTC: Attachment II, Section VI.A.1.c.)

If you have any questions, please contact your Agency contract manager.

Sincerely,

Austin Noll
Deputy Secretary
Medicaid Policy, Quality, and Operations

AN/jp
Attachment 1: LTC Notice of Adverse Benefit Determination Template
Attachment 2: MMA and Dental Notice of Adverse Benefit Determination Template
Attachment 3: MediKids Notice of Adverse Benefit Determination Template