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Medicaid Unwinding: Due Process Violations and Impacts in Florida

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Medicaid Unwinding: Due Process Violations and Impacts in Florida

Emma Page

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INTRODUCTION

During the COVID–19 pandemic, states continued to provide Medicaid benefits to individuals who were enrolled at the start of or during the emergency.[1] However, with the end of the continuous enrollment

[1] Bradley Corallo, et al., *Unwinding of Medicaid Continuous Enrollment: Key Themes from the Field*, KAISER FAMILY FOUNDATION (Jan. 10, 2024),

provision in March 2023, states began the process of "unwinding" by re–evaluating Medicaid eligibility on a large scale.[2] This transition led to the disenrollment of millions of people across the United States, leaving many without health insurance coverage.[3] In states like Florida that have not adopted ACA Medicaid Expansion, this process was particularly harmful, as eligibility requirements are already more stringent.[4]

This article will explore the issues encountered during the unwinding process in Florida, focusing on the problems caused by inadequate notices that likely resulted in thousands of procedural disenrollments.[5] The issues with notices were already present, but they have been significantly highlighted during the unwinding process.[6] This includes an analysis of Chianne D. v. Weida, a class action case brought against the Florida Agency for Health Care Administration and the Florida Department of Children and Families by Medicaid enrollees, whose coverage was terminated without adequate individualized written notice of the reason for the termination and the opportunity for a pre–termination fair hearing as the Constitution and Medicaid Act require.[7] It will also propose recommendations for Florida to improve its administrative processes and ensure that Floridians have the access to healthcare they deserve in the future.

A. *Introduction to Medicaid*

Enacted through Title XIX of the Social Security Act in 1965, the Medicaid program extends health insurance coverage to low–income

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https://www.kff.org/medicaid/issue–brief/unwinding–of–medicaid–continuous–enrollment–key–themes–from–the–field/.

2 Unwinding is the process of redetermining Medicaid eligibility which leads to subsequent renewal or disenrollment. *Id.*

3 *Id.*

4 Patricia Drake et al., *How Many Uninsured are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?*, THE HENRY J. KAISER FAMILY FOUNDATION (Feb. 26, 2024), https://www.kff.org/medicaid/issue–brief/how–many–uninsured–are–in–the–coverage–gap–and–how–many–could–be–eligible–if–all–states–adopted–the–medicaid–expansion/.

5 *See* Emily Zylla, Caroline Au–Yeung, Elizabeth Lukanen & Christina Worrall, *Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study: Case Study Summary Report – Florida*, STATE HEALTH ACCESS DATA ASSIST. CTR. 1, 12–13 (Oct. 19, 2018), https://www.macpac.gov/wp–content/uploads/2018/11/Florida–Summary–Report.pdf; *See* Complaint, Chianne D. v. Weida, No. 3:23–cv–00985 (M.D. Fla., Aug. 22, 2023).

6 *See* Complaint, Chianne D. v. Weida, No. 3:23–cv–00985 (M.D. Fla., Aug. 22, 2023).

7 *Id.*

individuals.[8] Every state, along with the District of Columbia and US territories, implements its own unique Medicaid programs.[9] Although the federal government sets general guidelines and parameters, Medicaid administrations—and coverage levels—vary between states.[10] The Medicaid Act establishes a healthcare assistance program funded by both the federal and state governments.[11]

Former President Obama signed the Affordable Care Act (ACA) in 2010, granting individual states the authority to expand Medicaid eligibility.[12] The ACA expansion extended coverage eligibility to individuals under sixty–five years old in families earning less than 133% of the Federal Poverty Level.[13] However, states are not required to accept federal Medicaid expansion.[14]

B. Medicaid in Florida

Florida implemented Medicaid in January of 1970.[15] From 1980 to 2004, Medicaid spending in Florida grew, and Florida applied for an 1115 waiver.[16] A 1115 waiver is used by a state wanting to implement experimental or pilot projects within its Medicaid program.[17] With this 1115 waiver, Florida implemented managed care in multiple counties.[18] In 2013, the federal government granted Florida's request to expand its pilot managed–care project statewide, benefitting low–income families in Florida.[19]

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8 *Program History*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.medicaid.gov/about–us/program–history/index.html (last visited Mar. 12, 2024).

9 *Id.*

10 *Id.*

11 42 U.S.C. §§ 1396–1396w–7 (2022).

12 *Program History*, *supra* note 8.

13 *Id.*

14 *See* National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012); *Medicaid and CHIP*, HEALTHCARE.GOV, https://www.healthcare.gov/medicaid–chip/medicaid–expansion–and–you/ (last visited Mar. 14, 2024).

15 *Medicaid eligibility and enrollment in Florida*, HEALTHINSURANCE.ORG, https://www.healthinsurance.org/medicaid/florida/ (last visited Mar. 14, 2024) [hereinafter *Medicaid eligibility and enrollment*].

16 *Id.*

17 *1115 waiver*, HEALTHINSURANCE.ORG, https://www.healthinsurance.org/glossary/1115–waiver/ (last visited Mar. 14, 2024).

18 *Medicaid eligibility and enrollment*, *supra* note 15.

19 The Office of Governor Rick Scott, *Gov. Rick Scott Announces Florida Receives Final Waiver Approval for Managed Medical Assistance Program*, FLORIDA AGENCY FOR HEALTH CARE ADMIN (Jun. 14, 2013), https://ahca.myflorida.com/content/download/16189/file/Gov__Rick_Scott_Announces_Florida_Receives_Final_Waiver_Approval_for_Managed_Medical_Assistance_Program.pdf.

Florida, joined by twenty–five other states, filed a constitutional challenge to ACA's individual mandate and Medicaid expansion provisions.[20] On June 28, 2012, the US Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, upholding the constitutionality of the ACA's individual mandate provisions.[21] The Court also ruled that the ACA's Medicaid expansion provisions were unconstitutionally coercive of the states because (1) states did not have adequate notice to voluntarily consent to this change in the Medicaid program and (2) existing federal Medicaid funding was at risk when a state was non–complaint.[22] After this decision, expansion became optional and voluntary for the states.

Florida is one of the ten remaining states who have opted not to accept expansion.[23] Individuals are stuck in a "coverage gap," having income too high to qualify for Medicaid and too low to qualify for tax subsidies that would help them pay for private health insurance.[24] Nineteen percent of the estimated 1.9 million individuals falling within the United States' coverage gap live in Florida.[25] Failing to expand Medicaid eligibility has created a major coverage gap for nearly 285,000 Floridians.[26]

Florida's current Medicaid eligibility standards are:

- Children up to one year old: 200% of the federal poverty level (FPL);
- Children aged one through eighteen: 133% of FPL;
- Children under age nineteen can qualify for Florida Healthy Kids, with modest monthly premiums, if household income is between 133% and 300% of FPL;

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20 MaryBeth Musumeci, *A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion*, THE HENRY J. KAISER FAMILY FOUNDATION (Aug. 2012), https://www.kff.org/wp–content/uploads/2013/01/8347.pdf.

21 *See* National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).

22 Musumeci, *supra* note 20.

23 *Medicaid eligibility and enrollment*, *supra* note 15.

24 Patricia Drake et al., *How Many Uninsured are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?*, THE HENRY J. KAISER FAMILY FOUNDATION (Feb. 26, 2024), https://www.kff.org/medicaid/issue–brief/how–many–uninsured–are–in–the–coverage–gap–and–how–many–could–be–eligible–if–all–states–adopted–the–medicaid–expansion/.

25 *Id.*

26 *Id.*

- Pregnant women: 196% of FPL (with coverage continuing for twelve months after the baby is born);
- Adults with minor children: 26% of FPL (This percentage changes as the federal poverty level changes, because Florida uses a flat dollar limit for Medicaid eligibility for parents, so it does not keep pace with the poverty level); and
- People who qualify for Supplemental Security Income (SSI) automatically qualify for Medicaid in Florida. [27]

In accordance with federal law, Florida has appointed the Agency for Health Care Administration (AHCA) as the exclusive state Medicaid agency.[28] The AHCA has assigned the task of handling Medicaid eligibility reassessments to the Department of Children and Families (DCF).[29] As the designated state agency, AHCA is obligated to oversee DCF's compliance with federal Medicaid laws and regulations.[30]

C. Impact of COVID–19 Pandemic

Since March 2020, the COVID–19 pandemic and its economic impact have significantly affected both Medicaid spending and enrollment.[31] At the onset of the pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA).[32] Section 6008 of the FFCRA provided an "increase of 6.2 percentage points to each qualifying State's and Territory's Federal Medical Assistance Percentage (FMAP), effective January 1, 2020," which increased the rate at which the federal government matched state spending.[33] FFCRA mandated that states

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[27] *2023 General Annual Income Guidelines* and *Program Eligibility Overview*, FLORIDA KIDCARE (Apr. 2024), https://www.floridakidcare.org/_docs/Florida_KidCare_Income_Guidelines.pdf; Medicaid eligibility and enrollment, *supra* note 15.

[28] Fla. Stat. § 409.902(1) (2023); *see also* 42 U.S.C. § 1396(a)(5) (2022).

[29] Fla. Stat. § 409.902(1) (2023).

[30] Fla. Stat. § 409.902 (1) (2023); 42 C.F.R. § 431.10(c)(3) (2022); *see also* Hernandez v. Medows, 209 F.R.D. 665, 670 (S.D. Fla. 2002).

[31] Elizabeth Williams, Robin Rudowitz &Alice Burns, *Medicaid Financing: The Basics*, THE HENRY J. KAISER FAMILY FOUNDATION (Apr. 13, 2023), https://www.kff.org/medicaid/issue–brief/medicaid–financing–the–basics/.

[32] *Families First Coronavirus Response Act*, Pub. L. No. 116–127, H.R.6201, 116th Cong. (2020), https://www.congress.gov/bill/116th–congress/house–bill/6201.

[33] *States' Medicaid Eligibility and Enrollment Actions Concluding the COVID–19 Public Health Emergency*, HHS OFFICE OF INSPECTOR GENERAL,

maintain Medicaid benefits for individuals enrolled at the start of or during the COVID–19 PHE as a condition to receive the increased FMAP.[34] States were required not to reassess Medicaid eligibility through the month in which the COVID–19 PHE ended, which was known as the "continuous enrollment period.[35]" These provisions led to a surge in Medicaid enrollment, reaching unprecedented levels of coverage and contributing to a decreased uninsured rate.[36]

Following the commencement of the COVID–19 pandemic, both Medicaid enrollment and overall spending experienced notable increases.[37] A recent analysis by the Kaiser Family Foundation (KFF) estimates that Medicaid/CHIP enrollment reached 92.3 million by December 2022, with one quarter of enrollees being new Medicaid recipients.[38] According to KFF's annual budget survey, the growth in total Medicaid spending (including federal and state funds) had been consistent since the beginning of the pandemic, and state Medicaid programs identified the increase in enrollment as the primary factor driving expenditure growth.[39]

The conclusion of the Medicaid continuous enrollment provision and the phased reduction of the enhanced FMAP have had notable consequences for Medicaid enrollment and spending.[40] Enacted through the Consolidated Appropriations Act at the close of 2022, Congress specified that the Medicaid continuous enrollment provision would cease on March 31, 2023, and the enhanced FMAP would be gradually scaled back until December 2023.[41] Although the precise number of Medicaid enrollees subject to disenrollment during this transition period was uncertain, research suggested that between five percent and seventeen

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https://oig.hhs.gov/reports–and–publications/workplan/summary/wp–summary–0000726.asp (last visited Aug. 15, 2024); *Families First Coronavirus Response Act*, Pub. L. No. 116–127, H.R.6201, 116th Cong. (2020), https://www.congress.gov/bill/116th–congress/house–bill/6201.

[34] HHS OFFICE OF INSPECTOR GENERAL, *supra* note 33.

[35] *Id.*

[36] *See id.*

[37] Bradley Corallo and Sophia Moreno, *Analysis of National Trends in Medicaid and CHIP Enrollment During the COVID–19 Pandemic*, THE HENRY J. KAISER FAMILY FOUNDATION (Apr. 04, 2023), https://www.kff.org/coronavirus–covid–19/issue–brief/analysis–of–recent–national–trends–in–medicaid–and–chip–enrollment/.

[38] *Id.*

[39] *Id.*

[40] Williams, *supra* note 31.

[41] *Id.*; Consolidated Appropriations Act, 2023, Pub. L. No. 117–328, H.R.2617, 117th Cong. (2022), https://www.congress.gov/bill/117th–congress/house–bill/2617/text; *Analysis of National Trends in Medicaid and CHIP Enrollment During the COVID–19 Pandemic*, *supra* note 29.

percent of existing enrollees may be affected.[42] This process of Medicaid eligibility redetermination and disenrollment is known as "unwinding.[43]"

D. Unwinding

States are responsible for their own unwinding timeline, however, there are guidelines they must follow through the review and renewal process.[44] They are required to conduct a thorough review of eligibility using current information to avoid termination based on outdated data.[45] Electronic data sources are first used to determine eligibility.[46] If electronic data sources are insufficient, a renewal form is sent to enrollees, who have at least 30 days to complete and return it.[47] Failure to do so may result in Medicaid coverage loss, with states required to provide a ten day notice before termination.[48] Some states offer online renewal options, while others mandate renewal by mail.[49]

Enrollees may lose Medicaid coverage during the unwinding process due to eligibility reasons or procedural reasons.[50] Eligibility reasons include changes in circumstance, for example, if income goes up or household size goes down.[51] Recipients may also lose coverage due to procedural reasons, including administrative errors, paperwork issues, or renewal barriers.[52]

E. Consequences of Unwinding

The Medicaid unwinding process led to an unprecedented reduction in coverage, over a two–year period in the history of the program, marking the most significant decrease in the program's history.[53] Communities of color are overrepresented in the Medicaid population and account for over 50 percent of people losing coverage during the unwinding.[54] Based on

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42 Williams, *supra* note 31.

43 *Id.*

44 HEALTH REFORM BEYOND THE BASICS, *Unwinding Medicaid Continuous Coverage* (Feb. 2023), https://www.healthreformbeyondthebasics.org/wp–content/uploads/2023/01/FAQ–Unwinding–Medicaid–Continuous–Coverage.pdf.

45 *Id.*

46 *Id.*

47 *Id.*

48 *Id.*

49 *Id.*

50 HEALTH REFORM BEYOND THE BASICS, *supra* note 44.

51 *Id.*

52 *Id.*

53 Theresa Lau, *'Medicaid Unwinding' Harms Millions of People, Especially Communities of Color*, S. POVERTY LAW CTR. (Nov. 29, 2023), https://www.splcenter.org/hopewatch/2023/11/29/medicaid–unwinding–harms–millions.

54 *Id.*

data from the Kaiser Family Foundation, at least 24,838,000 Medicaid enrollees have been disenrolled as of August 1, 2024 from all fifty states and Washington, D.C..[55] Across all states, sixty–nine percent of disenrollments were procedural.[56] Since the start of the unwinding, national Medicaid/CHIP enrollment has declined by 13.2 million, or 13.9% nationally since April 2024.[57]

There are numerous barriers an enrollee may face during the unwinding process.[58] These issues often result from the enrollees' personal circumstances or inherent issues with the administration of Medicaid. If an enrollee moved during the pandemic, they may not receive notices or renewal forms sent to an outdated address.[59] Due to structural racism, Black and Latino enrollees are more likely to have experienced employment or housing instability during the pandemic, leading to a greater risk of this error occurring.[60] Additionally, even when renewal forms are received by the enrollee, their contents may be unclear or confusing. For enrollees with limited English proficiency, the difficulties surrounding notices and the renewal process are compounded.[61] Finally, individuals with questions about the process may struggle to reach the Medicaid agency's call center due to extended wait times or lack of clarity regarding who to contact with questions about the process.[62]

In November 2023, The Kaiser Family Foundation released a comprehensive report presenting key insights derived from focus groups conducted in September 2023.[63] The report delved into various aspects of the unwinding, including participants' experiences with Medicaid, awareness of the continuous enrollment provision, the renewal process, repercussions of disenrollment, and current insurance status.[64] Notably, the report highlighted a considerable variation in awareness among

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55 *Medicaid Enrollment and Unwinding Tracker*, THE HENRY J. KAISER FAMILY FOUNDATION (Aug. 1, 2024), https://www.kff.org/report–section/medicaid–enrollment–and–unwinding–tracker–overview/.

56 *Id.*

57 *Id.*

58 HEALTH REFORM BEYOND THE BASICS*, supra* note 44.

59 *Id.*

60 *Id.*

61 *Id.*

62 *Id.*

63 Amaya Diana, Jennifer Tolbert, Robin Rudowitz & Bradley Corallo, *Navigating the Unwinding of Medicaid Continuous Enrollment: A Look at Enrollee Experiences*, THE HENRY J. KAISER FAMILY FOUNDATION (Nov. 9, 2023), https://www.kff.org/medicaid/report/navigating–the–unwinding–of–medicaid–continuous–enrollment–a–look–at–enrollee–experiences/.

64 *Id*.

participants regarding the initiation of Medicaid disenrollments in their respective states.[65]

Among those who successfully renewed their Medicaid coverage online, the consensus was that the process was efficient and relatively straightforward.[66] However, many participants encountered obstacles, including difficulties in submitting required paperwork and prolonged processing times.[67] Additionally, others faced challenges in comprehending notices and other documents from their states, along with issues related to call center interactions.[68] This analysis provides valuable insights into the diverse experiences and challenges faced by individuals navigating the Medicaid system.[69]

Participants in the study lost coverage for a variety of reasons, but some still did not know why they were disenrolled.[70] Several participants faced substantial out–of–pocket costs for medically necessary care during the gaps their disenrollment created in health insurance coverage.[71] Several participants required one–on–one assistance from caseworkers or community–based organization.[72] Of the participants who lost Medicaid, some obtained Affordable Care Act Marketplace Insurance, while others remain uninsured.[73]

Most participants highlighted health–related and financial consequences that would occur with Medicaid disenrollment.[74] Participants described their loss of Medicaid and consequent access to lifesaving medications and treatment, as "devastating.[75]" They also expressed decline in physical and mental health.[76]

II. IMPACTS OF UNWINDING IN FLORIDA

A. Background

The state of Florida provided continuous Medicaid coverage from the beginning of the COVID–19 PHE, resulting in a significant increase in Medicaid recipients—from 3.8 million enrolled in March of 2020 to 5.5

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65 *Id.*
66 *Id.*
67 *Id.*
68 *See id.*
69 Diana, Tolbert, Rudowitz & Corallo, *supra* note 63.
70 *Id.*
71 *Id.*
72 *Id.*
73 *Id.*
74 *Id.*
75 Diana, Tolbert, Rudowitz & Corallo, *supra* note 63.
76 *Id.*

million enrolled in November of 2022.[77] The Florida DCF explained on their website that they would undertake the task of unwinding Medicaid enrollment by "scheduling and conducting redeterminations in a manner that will meet federal regulatory requirements while minimizing the impact on families.[78]" The DCF has not lived up to this promise.

In Florida, 1.9 million residents have been disenrolled from Medicaid since the start of the unwinding.[79] The disenrollment rate is 38 percent, the thirteenth highest in the country.[80] Of all people who were disenrolled in Florida, sixty–four percent were terminated for procedural reasons, while only thirty–six percent were determined to be ineligible for Medicaid with updated information.[81]

Perhaps the worst consequences of the unwinding are the impacts on Florida's children.[82] At the midpoint of the state's redetermination process, nearly 250,000 children were deemed ineligible for Medicaid.[83] As of November 2023, DCF has disenrolled around 260,000 children from Medicaid across the state.[84] The state intended for qualifying children to enter Florida's "KidCare" plan, however, that has not come to fruition as only 25,000 children have enrolled.[85]

B. *Chianne D. v. Weida*

1. Case Background

Chianne D. v. Weida was filed in the United States District Court for the Middle District of Florida, Jacksonville Division, on August 22, 2023.[86] Plaintiffs, represented by attorneys from the Florida Health Justice Project and the National Health Law Program, submitted a verified class action complaint for declaratory and injunctive relief against the Florida Agency for Health Care Administration and the Florida Department of

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77 *Medicaid Redetermination*, FLA. DEPT. OF CHILDREN & FAMILIES (2024), https://www.myflfamilies.com/medicaid.

78 *Id.*

79 *Medicaid Enrollment and Unwinding Tracker*, *supra* note 55.

80 *Id.*

81 *Id.*

82 Joe Mario Pederson, *Thousands of Florida children appear not to have Coverage in Medicaid Unwinding*, CENT. FLA. PUB. MEDIA (Nov. 13, 2023, 5:00 PM), https://www.wmfe.org/health/2023–11–13/thousands–children–florida–without–coverage–after–medicaid–unwinding.

83 *Id.*

84 *Id.*

85 *Id.*

86 Complaint at 39, Chianne D. v. Weida, No. 3:23–cv–00985 (M.D. Fla. Aug. 22, 2023) [hereinafter *Complaint*].

Children and Families.[87] Plaintiffs allege that "[d]efendants are terminating tens of thousands of Floridians from Medicaid coverage without providing them adequate individualized written notice of the reason for the termination and the opportunity for a pre–termination fair hearing as the Constitution and Medicaid Act require.[88]"

This class action complaint challenges the standardized notices that Florida used to inform Medicaid enrollees of their ineligibility for Medicaid coverage.[89] The notices routinely failed to include the legal or factual basis for the agency's decision, instead the notices used sets of standardized "reason codes.[90]" The reason codes only confuse enrollees and provide little or no basis for the agency's decision.[91] Notices with reason codes, known as standardized notices have generated confusion for beneficiaries for years due to the ineligibility explanations not being sufficiently explicit.[92] The AHCA and DCF did not remedy the clear deficiencies in their notices prior to restarting eligibility determinations in the unwinding process.[93]

Due to state agencies' failure to remedy notice deficiencies, Plaintiffs and other class members are losing their Medicaid coverage without proper, meaningful, or adequate notice.[94] Individuals losing Medicaid coverage in Florida are unable to understand the decisions of the agency, comprehend the process to contest their disenrollment, or plan for coverage that minimizes disruption in their healthcare.[95] Lack of Medicaid coverage leads to loss of access to medical necessities, such as prescription drugs, vaccinations, and postpartum care.[96]

2. Plaintiffs

Plaintiff Chianne D., a Jacksonville, Florida resident, lives with her husband and two children.[97] Her child, C.D., was diagnosed with Cystic

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87 *Id.*
88 *Id.* at 1.
89 *Id.* at 2.
90 *Id.*
91 *Id.*
92 *Id.* at 2–3; Emily Zylla, Caroline Au–Yeung, Elizabeth Lukanen & Christina Worrall, *Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study: Case Study Summary Report – Florida*, STATE HEALTH ACCESS DATA ASSIST. CTR. 1, 12–13 (Oct. 19, 2018), https://www.macpac.gov/wp–content/uploads/2018/11/Florida–Summary–Report.pdf.
93 Complaint, *supra* note 86, at 3.
94 *Id.*
95 *Id.*
96 *Id.*
97 *Id.* at 29.

Fibrosis in 2021 and has been a Medicaid recipient since that time.[98] C.D. requires significant medical care, from expensive prescription drugs to medical daycare.[99] In February 2023, Chianne qualified for twelve months of continuous Medicaid coverage, extending until at least February 2024.[100] However, on April 24, 2023, the Florida Department of Children and Families (DCF) issued a notice denying Medicaid for Chianne and her family, citing "high income" and "receiving assistance from another program.[101]" The notice was confusing and did not provide information on alternative coverage.[102] Chianne, seeking clarification from DCF, faced unhelpful responses from a representative.[103]

The notice did not inform Chianne about potential coverage for her son, C.D., nor did it convey the option for Chianne to pursue a fair hearing to challenge her own loss of coverage.[104] Consequently, Chianne and C.D. lost Medicaid on May 31, 2023.[105] In June, without coverage, C.D. missed necessary medical care, leading to health issues and an emergency room visit.[106] Chianne incurred medical bills, causing financial strain, and the family was saving to pay off the hospital bill.[107] The stress from these financial burdens was significant.[108]

Chianne managed to enroll C.D. in Florida's CHIP coverage in July 2023, costing $248 monthly, but Chianne herself remains without coverage.[109] Despite falling ill in June and July of 2023, she was unable to see a doctor due to the lack of insurance.[110]

Plaintiff A.V., a one–year–old residing in an eight–person household in Miami–Dade County, lost Medicaid coverage abruptly in June 2023.[111] The confusing 8–page notice from DCF on May 16, 2023 lacked clarity and provided inconsistent information about Medicaid termination.[112] A.V.'s parents struggled to understand the notice, leading to uncertainty about their daughter's eligibility status.[113] Despite their efforts to seek information from various sources, including Medicaid managed care and

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98 *Id.*
99 *Id.* at 30.
100 *Id.*
101 *Id.*
102 *Id.* at 31.
103 *Id.*
104 *Id.* at 32.
105 *Id.*
106 *Id.* at 32.
107 *Id.* at 32–33.
108 *Id.* at 33.
109 *Id.*
110 *Id.*
111 *Id.*
112 *Id.* at 33–35.
113 *Id.* at 35.

the KidCare program, the family remains completely perplexed about A.V.'s loss of eligibility.[114] A.V.'s mother recognizes the importance of insurance for A.V.'s medical needs, including vaccinations.[115] The loss of coverage poses a significant risk of potential health issues, and A.V. currently remains without Medicaid coverage.[116] These plaintiffs provide two clear examples of the negative impacts unwinding has created for Florida residents since unwinding began.

3. Claims

Multiple causes of action and potential legal issues with Florida's Medicaid unwinding process arise in this case.[117] First, the Due Process Clause of the Fourteenth Amendment prevents the state from terminating a person's property rights, including Medicaid benefits, without adequate notice and an opportunity to be heard.[118] The defendants are accused of violating this constitutional right by creating a risk of incorrect Medicaid coverage termination, failing to provide timely and effective notice, and not offering a meaningful opportunity for a fair hearing before terminating Medicaid coverage.[119] The plaintiffs are seeking relief under 42 U.S.C. § 1983, which allows legal action to redress the denial of constitutional rights by individuals acting under the authority of state law.[120]

The second cause of action is through violation of the Medicaid Act, 42 U.S.C. § 1396(a)(3).[121] The Medicaid Act mandates that state programs must offer a fair hearing opportunity to individuals whose medical assistance claims are denied or not promptly addressed.[122] The defendants are alleged to have consistently failed in providing timely notice of decisions or enrollees' rights regarding Medicaid coverage.[123] In addition, defendants here failed to offer a fair hearing before terminating coverage.[124] The plaintiffs, again, seek relief under 42 U.S.C. § 1983.[125]

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114 *Id.*
115 *Id.* at 35–36.
116 *Id.* at 36.
117 *See id.* at 36–38.
118 *Id.* at 36; *see* U.S. CONST. amend. XIV, § 1.
119 Complaint, *supra* note 86, at 36–37.
120 *Id.* at 37.; 42 U.S.C. § 1983.
121 Complaint, *supra* note 86, at 37; 42 U.S.C. § 1396a(a)(3) (2022).
122 Complaint, *supra* note 86, at 37 (quoting 42 U.S.C. § 1396a(a)(3) (2022)).
123 Complaint, *supra* note 86, at 37.
124 *Id.*
125 *Id.* at 38; 42 U.S.C. § 1983.

III. LEGAL ANALYSIS

A. *Constitutional Due Process*

The Due Process Clause of the Fourteenth Amendment in the U.S. Constitution prohibits a state from rescinding an individual's property, including Medicaid benefits, without giving the individual sufficient advance notice and an opportunity to be heard before terminating the benefits.[126] In *Goldberg v. Kelly*, the preeminent case on due process notice requirements, the U.S. Supreme Court stated that, prior to discontinuing federal welfare benefits, agencies are obligated to provide timely and adequate written notice "detailing the reasons for a proposed termination" that aligns with the standards of due process.[127] Medicaid recipients have a statutory entitlement to benefits that is protected by the Due Process Clause of the Fourteenth Amendment and, therefore, the Government cannot withdraw direct benefits without giving patients notice and opportunity for a hearing, as stated in *O'Bannon v. Town Court Nursing Ctr.*[128]

In *Mullane v. Central Hanover Bank & Trust Co*., the Supreme Court further outlined notice requirements, stating that "an elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.[129]" Additionally, the notice must reasonably convey the "required information.[130]" Due process also requires that beneficiaries are provided

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[126] U.S. Const. amend. XIV, § 1; Goldberg v. Kelly, 397 U.S. 254, 267–68 (1970).

[127] *Goldberg*, 397 U.S. 254 at 267–68 (holding when a state intends to cease welfare benefits, procedural due process mandates that the state furnish the recipient with a pre–termination evidentiary hearing, and this hearing is conducted to ascertain the validity of discontinuing public assistance, aiming to safeguard the recipient against any erroneous termination of benefits); *cf.* Mathews v. Eldridge, 424 U.S. 319, 321 (1976) (discussing the balancing test that should be used to determine the due process rights accorded beneficiaries when contested benefits are not conditioned upon financial need). In cases where procedural due process is at issue, which case law applies depends on the nature of the contested benefits. This balancing test involves weighing the private interest affected by the official action, the risk of erroneous deprivation through the procedures used, and the probable value of additional or substitute procedural safeguards, as well as the fiscal and administrative burdens that additional or substitute procedural requirements would entail. Here, the *Mathews* test was not applied.

[128] O'Bannon v. Town Court Nursing Ctr., 447 U.S. 773, 786–787 (1980). *O'Bannon* did not involve the withdrawal of direct benefits, but decertification for Medicaid purposes of a particular skilled nursing facility, which the Supreme Court held did not amount to a deprivation of life, liberty, or property.

[129] Mullane v. Cent. Hanover Bank & Tr. Co., 339 U.S. 306, 314 (1950).

[130] *Id.*

with some administrative procedure for consideration of complaints prior to termination of services, in order to afford reasonable assurance against erroneous or arbitrary withholding of services.[131]

B. *Medicaid Act*

The Medicaid Act outlines requirements for all state programs to "provide for granting an opportunity for a fair hearing before the state agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.[132]" Under the Medicaid Act, notices must include a statement of the proposed action, a clear statement of the reasons supporting the action, an explanation of the right to a hearing, and a method for obtaining a hearing.[133] Where the required notice is not provided, due process and the Medicaid Act require Medicaid coverage to be reinstated until the aforementioned pre–termination hearing is provided.[134] As to both Counts, Plaintiffs are challenging the adequacy of notice and right to a hearing, and seek relief pursuant to 42 U.S.C. § 1983.[135]

C. *The Role of Adequate Notice*

The Due Process Clause of the Fourteenth Amendment and the Medicaid Act both require procedural due process—including adequate notice and the opportunity for a pre–termination hearing—before insurance coverage may be terminated. The decision in *Chianne D. v. Weida* will depend on whether the notices provided by DCF were adequate and whether they provided the opportunity for Medicaid recipients to be heard. Courts outside of Florida have emphasized the factors that create adequate notice.

The Supreme Court of Alaska, in *Allen v. Alaska Dept. of Health & Social Services*, explained that a major purpose served by benefit change or denial notices is protecting recipients from erroneous deprivation of benefits and agency mistakes; such notices should provide enough

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131 Memphis Light, Gas & Water Div. v. Craft, 436 U.S. 1, 18 (1978) (finding a due process violation where notice was adequate to apprise the plaintiffs of the threat of termination, but not reasonably calculated to inform them of their opportunity to present their objections).

132 42 U.S.C. § 1396a(a)(3) (2022); Complaint, *supra* note 86, at 37.

133 42 U.S.C. § 1396a(a)(3) (2022); 42 C.F.R. § 431.206(b)(2) (2024); 42 C.F.R. § 431.210 (2024); *see also* 42 C.F.R. § 431.205 (2024).

134 Kimble v. Solomon, 599 F.2d 599, 605 (4th Cir. 1979) (ordering "prospective reinstatement of [Medicaid] benefits . . . until at least ten days after Maryland has mailed to each plaintiff a separate, timely and adequate notice"); 42 C.F.R. § 431.231(c)(1) (2024); Goldberg v. Kelly, 397 U.S. 254, 264 (1970).

135 Complaint, *supra* note 86, at 36–38.

information to allow recipients to detect and challenge potential mistakes.[136] As the District Court of the Northern District of Georgia stated in *C.R. ex rel. Reed v. Noggle*, notices that inform recipients that requests for Medicaid benefits are denied due to "not [being] entitled to those benefits," this circular reasoning is deficient.[137] In *Barnes v. Healy*, the Ninth Circuit Court of Appeals held that the explanation in the notice itself must be more than a "general explanation" or "conclusory statement" and must provide at least "a brief statement of [the decision's] factual underpinnings.[138]"

The requirement of "adequate notice detailing the reasons" from *Goldberg v. Kelly* is supported by ample case law.[139] For example, in *Perdue v. Gargano* the court stated that "merely offering applicants information from which they could potentially deduce the reasons for a denial is no process at all. Notice must be unambiguous so that applicants can know the precise reason for which they were denied benefits and can determine the accuracy of the State's determination.[140]"

In *Doston v. Duffy*, the U.S. District Court for the Northern District of Illinois noted that a notice that is "unintelligible, confusing, or misleading" is inadequate.[141] In addition, the Seventh Circuit Court of Appeals has decided three major cases holding that due process requires more than a statement of the ultimate reason for the adverse state action. In *Banks v. Trainor*,[142] *Vargas v. Trainor*,[143] and *Dilda v. Quern*,[144] the court ruled in favor of beneficiaries whose benefits had been terminated, and emphasized that "providing affected individuals with notice explaining in detail the reasons underlying the state's adverse decision empowers

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[136] Allen v. Alaska Dep't of Health & Soc. Servs., Div. of Pub. Assistance, 203 P.3d 1155, 1167–68, n.61 (Alaska 2009).
[137] C.R. ex rel. Reed v. Noggle, 559 F. Supp. 3d 1323, 1339 (N.D. Ga. 2021) (quoting *Goldberg*, 397 U.S. at 267).
[138] Barnes v. Healy, 980 F.2d 572, 579 (9th Cir.1992).
[139] *Goldberg*, 397 U.S. at 254.
[140] Perdue v. Gargano, 964 N.E.2d 825, 838 (Ind. 2012) (holding that notices used by the FSSA to inform individuals that their applications for Medicaid, Food Stamp, or TANF benefits have been denied do not satisfy the requirements of due process).
[141] Doston v. Duffy, 732 F. Supp. 857, 872–73 (N.D. Ill. 1988).
[142] *See* Banks v. Trainor, 525 F.2d 837 (7th Cir.1975) (holding that a benefit reduction notice providing only income and new and old benefits amounts was inadequate because it lacked a breakdown of income and deductions so that recipients could determine the accuracy of the agency's computations).
[143] *See* Vargas v. Trainor, 508 F.2d 485 (7th Cir.1974) (holding that the notice reasoning of "changes in your needs or living arrangement . . . but which were not entered on your record" was inconsistent with due process requirements and did not adequately state the reasons for the proposed action).
[144] *See* Dilda v. Quern, 612 F.2d 1055 (7th Cir.1980) (holding that due process requires more than a statement of the ultimate reason for an adverse state action).

individuals to protect their own interests and complements the state's efforts to achieve accuracy.[145]" The rationale of these cases has also been adopted in the Third Circuit.[146] In short, without "sufficient information to understand the basis for the agency's action," Medicaid enrollees "cannot know whether a challenge to an agency's action is warranted, much less formulate an effective challenge.[147]"

The Eleventh Circuit and its corresponding district courts have heard a small number of cases related to government benefit notice requirements. In *Gaines v. Hadi*, the U.S. District Court for the Southern District of Florida stated that due process involves the procedures, rather than substance, of state's decision–making.[148] The court cited *Kapps v. Wing*, stating that "due process simply requires that the agency make the reasons for its decision plain so that the opposing party can evaluate and challenge them.[149]"

The Eleventh Circuit Court of Appeals, in *Arrington v. Helms*, explained that to determine the adequacy of a state's notice of decision under the Due Process Clause, courts are to apply the test set forth in *Mullane v. Central Hanover Bank & Trust Co.*[150] The task allocated to courts is to determine whether the notice the plaintiffs currently receive is reasonable, not necessarily ideal.[151] Hence, "in order to be constitutionally adequate, notice of benefits determinations must provide claimants with enough information to understand the reasons for the agency's action,[152] [because] . . . claimants cannot know whether a challenge to an agency's action is warranted, much less formulate an effective challenge, if they are not provided with sufficient information to understand the basis for the agency's action.[153]" Under this standard, the court in *Gaines v. Hadi* stated, "it is not enough to have an opportunity to respond, in other words, if one has no idea of the reasons for the adverse decisions in the first place.[154]" The *Gaines* court held that the defendants adequately, perhaps not ideally,

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[145] *See Gargano*, 964 N.E.2d at 835.
[146] *See* Ortiz v. Eichler, 794 F.2d 889, 894 (3d Cir. 1986).
[147] Kapps v. Wing, 404 F.3d 105, 124 (2d Cir. 2005).
[148] Gaines v. Hadi, No. 06–60129–CIV–SEITZMC, 2006 WL 6035742, at *12 (S.D. Fla. Jan. 30, 2006).
[149] *Gaines*, 2006 WL 6035742, at *12 (citing *Kapps*, 404 F.3d at 123–24).
[150] Arrington v. Helms, 438 F.3d 1336, 1349 (11th Cir. 2006) (citing *Mullane v. Cent. Hanover Bank & Tr. Co.*, 339 U.S. 306 (1950).
[151] *Helms*, 438 F.3d at 1349–50.
[152] *Kapps*, 404 F.3d at 123.
[153] *Id.* at 124.
[154] *Gaines*, 2006 WL 6035742, at *13.

notified Plaintiffs of the reason for their decision to reduce Medicaid services, so procedural due process was satisfied.[155]

IV. APPLICATION TO *CHIANNE D. V. WEIDA*

"Procedural due process requires both fair notice and a real opportunity to be heard.[156]" The plaintiffs in *Chianne D. v. Weida* allege that defendants have purportedly violated the Fourteenth Amendment and Medicaid Act's requirements in multiple ways.[157] First, they introduced a risk of inaccurate deprivation of Medicaid coverage.[158] Second, they did not furnish timely and effective notice regarding the basis for the agency's decision or the enrollees' rights and responsibilities concerning their Medicaid coverage.[159] Third, they failed to provide a meaningful opportunity for a fair hearing and timely corrective action before the termination of Medicaid coverage.[160]

The plaintiffs' claims are supported by the fact that the Department of Children and Families has consistently fallen short, both historically and presently, in delivering prompt and efficient notification regarding the reasons for the agency's decisions and the enrollee's rights and responsibilities related to their Medicaid coverage.[161] The issues regarding DCF's administration of Medicaid are preexisting but especially highlighted during this period of mass disenrollment. Furthermore, the department has neglected to offer a fair hearing and timely corrective measures before terminating Medicaid coverage when required.[162]

In 2018, the State Health Data Assistance Center within the Division of Health Policy and Management at the University of Minnesota's School of Public Health prepared a Case Study Summary Report regarding Medicaid Eligibility, Enrollment, and Renewal Processes and Systems.[163]

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155 *Gaines* at *17–18. Adequate notices here included reference to the applicable standards of medical necessity and residential habilitation, generally listed the various types of information relief upon by the reviewers and identified the factors the Agency deemed pertinent to the decision, generally offer a rationale or explanation for the decision, and are accompanied by a detailed notification that Plaintiffs can request a fair hearing to present evidence and challenge the Agency's reduction in services.
156 Keys Citizens for Responsible Gov't, Inc. v. Fla. Keys Aqueduct Auth., 795 So. 2d 940, 948 (Fla. 2001); Henderson v. Dep't of Health, Bd. of Nursing, 954 So. 2d 77, 80 (Fla. 5th DCA 2007).
157 Complaint, *supra* note 86, at 36–37.
158 *Id.* at 36.
159 *Id.*
160 *Id.* at 37.
161 *Id.*
162 *Id.*
163 Zylla, Au–Yeung, Lukanen & Christina Worrall, *supra* note 92, at ii–1.

This Report showcases the existing deficiencies in Florida's Medicaid administration, prior to the start of the COVID–19 public health emergency. DCF respondents involved in the study reported that notices sent to beneficiaries generate confusion.[164] They emphasized the need to establish a new, more robust notice platform once resources become available.[165] The DCF respondents described the new system ideally allowing notices to be more case–specific ("for example, current notices that describe applicants as ineligible are considered to be not sufficiently explicit in terms of an explanation") and to take into consideration the readability of notices.[166] Enrollment assisters also helped consumers interpret DCF notices, such as denial notices or notices of case action (which require additional information from beneficiaries).[167]

> One respondent provided the following description of notices: What I'm finding, regardless of whether it's in English or in Spanish, and regardless of whether it's in the native language of the person, the person doesn't understand. It's almost like being in a candy store where you have too many different candies to choose from. They get so much information with so many dates and so many deadlines, and they don't understand what it means. It's not written in simple English, it's not clear, they don't get it . . . I think most consumers, when they get the news that they're ineligible for services, whatever it is, under whatever program, they don't hear what follows, they just hear you're ineligible for this. So, they don't hear you may still be eligible for whatever else. So that makes it really difficult for consumers because they don't typically take the next step to find these other programs and these other services.[168]

State DCF respondents highlighted improvements over the last ten years with simplifying and clarifying notices, but this work was ongoing.[169]

The main issues with DCF Medicaid administration arise from their standardized notices. DCF utilizes standardized notices that are generated by a computer system to inform an individual that he or she is no longer

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[164] *Id.* at 12.
[165] *Id.* at 12–13.
[166] *Id.* at 13.
[167] *Id.* at 10.
[168] *Id.*
[169] *Id.*

eligible for Medicaid. If individuals listed in a given section are not eligible, the notice is populated with "reason codes." However, according to exhibits from *Chianne D. v. Weida*, a single notice may state that an individual is both "eligible" and "ineligible.[170]" Additionally, some statements, such as "RECEIVING THE SAME TYPE OF ASSISTANCE FROM ANOTHER PROGRAM" and "ELIGIBLE FOR MEDICAID UNDER A DIFFERENT MEDICAID COVERAGE GROUP," are present on forms where coverage is ending altogether, which is understandably misleading.[171] In notice sections where some household members are eligible and others are not, there may be no reason given whatsoever regarding that decision.[172] The plaintiffs, as well as other similarly situated individuals, are baffled by their redetermination notices from DCF—and DCF has been aware of this problem since at least 2018.

Where an entire household is deemed ineligible, the entire explanation is based on a single reason code.[173] Some reason codes, including "YOUR MEDICAID FOR THIS PERIOD IS ENDING"[174] and "NO HOUSEHOLD MEMBERS ARE ELIGIBLE FOR THIS PROGRAM,[175]" are entirely conclusory and do not appear to include a reasonable basis for the decision, replicating the "circular reasoning" rejected by *C.R. ex rel. Reed v. Noggle.*[176]

Other reason codes mentioned in *Chianne D. v. Weida* do identify income as a relevant eligibility factor.[177] However, the (example) phrase "YOUR HOUSEHOLD'S INCOME IS TOO HIGH TO QUALIFY FOR THIS PROGRAM" does not involve calculations of income, an explanation of what income DCF considers, or relevant eligibility limits.[178] Confusion about the reasoning behind the decision prevents beneficiaries from pursuing appeals because, as mentioned in *Kapps v. Wing*, there is not enough information to understand the reasoning for the agency's action.[179] The exhibits introduced by the Plaintiffs reveal that DCF only included the names of individuals and dates.[180] The notices lacked information regarding age, pregnancy, postpartum, or disability

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[170] Plaintiffs' Motion for a Classwide Preliminary Injunction at 7, Chianne D. v. Weida, No. 3:23–cv–00985 (M.D. Fla. Aug. 22, 2023) [hereinafter *Plaintiff's Motion for Preliminary Injunction*].
[171] *Id.* at 8.
[172] *Id.* at 9.
[173] *Id.*
[174] *Id.* at 10, Ex. 9 DCF Reason Codes List #520.
[175] *Id.* at 9, Ex. 9 DCF Reason Codes List #374.
[176] C.R. ex rel. Reed v. Noggle, 559 F. Supp. 3d 1323, 1339 (N.D. Ga. 2021).
[177] Plaintiff's Motion for Preliminary Injunction, *supra* note 170, at 10.
[178] *Id.* at 9–10, Ex. 9 DCF Reason Codes List #241.
[179] Kapps v. Wing, 404 F.3d 105, 123–124 (Fla. 2nd Cir. 2005).
[180] Plaintiff's Motion for Preliminary Injunction, *supra* note 170, at 11.

status, and whether this information was used to evaluate the individuals' eligibility.[181]

Finally, each notice includes the same standard paragraph regarding how to request a hearing—the notice template reads "If you want a hearing, you must ask for the hearing by writing, calling the call center or coming into an office within 90 days from the date at the top of this notice.[182]" However, there are no addresses listed to deliver a written request, no phone number for a call center, or any physical address of any DCF office.[183] Even if the information was provided, there are few physical offices in Florida, and the Florida call centers have the longest wait time and highest call abandonment rates in the country.[184] Spanish–language callers have an even worse experience.[185] Additionally, the notices lack information about submitting an appeal online or via email.[186]

Overall, DCF has been sending standardized notices with reason codes that are misleading, confusing, and sometimes senseless, while failing to provide the information beneficiaries need to appeal the decision terminating their Medicaid coverage.[187] DCF has been well–aware of the deficiencies in their notice system for years, and continued to rely on their lackluster reason codes to notify hundreds of thousands of Floridians that they are losing Medicaid coverage.[188] Based on the facts of *Chianne D*. and relevant precedent, it seems inevitable that the District Court for the Middle District of Florida will, and should, rule in favor of the Plaintiffs.

V. PROPOSED RULING

The court should rule in favor of the plaintiffs, as the Department of Children and Families urgently needs to reform its practices. Floridians should not bear the brunt of DCF's flawed execution of the unwinding process. The court should issue a declaratory judgment, pursuant to 28 U.S.C. § 2201[189] and Fed. R. Civ. P. 57,[190] stating that the standardized

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181 *Id.*

182 *Id.* at 12, Ex. 13 – DCF Template Notice of Medicaid Ineligibility.

183 *Id.*

184 Complaint, *supra* note 86, at 28.

185 *See* Unidos US, *At Florida's Medicaid call center, long and discriminatory delays prevent eligible families from keeping their health care*, UNIDOS US (Aug. 2023), https://unidosus.org/publications/long–and–discriminatory–delays–at–floridas–call–center/ (reporting that the average Spanish–language caller must wait nearly two and a half hours, and 30% of Spanish language calls are disconnected).

186 Complaint, *supra* note 86, at 12–13.

187 Complaint, *supra* note 86, at 28.

188 *See id at 29.*

189 *See generally* 28 U.S.C. § 2201 (2022).

190 *See generally* Fed. R. Civ. P. 57.

notices from the Defendants communicating Medicaid ineligibility violate Plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment and the Medicaid Act. Additionally, the court should grant preliminary and permanent injunctive relief, prohibiting Defendants from persisting in their illegal policies and practices. It should further mandate reinstatement of Medicaid coverage for Plaintiffs and all affected class members until they receive timely and legally adequate notice of termination.[191]

Moreover, a favorable ruling for the plaintiffs would carry significant implications. Primarily, it would safeguard current enrollees in Florida from being disenrolled from Medicaid through an unconstitutional process. Furthermore, it would compel the Department of Children and Families to reinstate coverage for those who have been disenrolled and properly manage Medicaid notices as they revisit the unwinding process. This not only aids Medicaid recipients in need of healthcare in Florida, but also encourages enhancements in notices and the overall system utilized by the Department of Children and Families in the future.

Moreover, a ruling favoring the plaintiffs would establish a precedent for other states to emulate the actions of the Florida Health Justice Project and National Health Law Program. There is evidence that similar practices during the unwinding process may have occurred in other states.

For example, in Pennsylvania, the Department of Human Services (DHS), the entity responsible for Medicaid and CHIP administration, has been facing faulty technology, staffing shortages, and flawed procedures.[192] Since April of 2023, tens of thousands of Pennsylvanians may have wrongly had their benefits terminated due to the DHS conducting household–level reassessments where paperwork is required from each household member if the income limits within the household varied.[193] If one member failed to return paperwork, their coverage was terminated.[194] Federal officials instructed states to automatically reenroll people on an individual level, but Pennsylvania's system is not equipped for automatic reenrollment, which has led to overextended caseworkers having to manually check publicly available income data to assess

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[191] Case Update as of August 23, 2024: A bench trial, held before Judge Marcia Morales Howard, began on August 1, 2024, and was completed on August 2, 2024. Proposed findings of fact and conclusions of law were due on September 19, 2024. The case is ongoing. *See* Bench Trial – Completed at *1, Chianne D. v. Weida, No. 3:23–cv–00985 (M.D. Fla. Aug. 02, 2024) [hereinafter *Bench Trial]*.

[192] Katie Meyer, *Bad tech, staffing shortages hinder Pa. as it reassesses health care coverage for 1000s*, SPOTLIGHT PA (Oct. 23, 2023), https://www.spotlightpa.org/news/2023/10/pennsylvania–medicaid–chip–health–insurance–covid–pandemic–unwinding/.

[193] *Id.*

[194] *Id.*

eligibility.[195] Pennsylvania has also struggled to identify those who were wrongly terminated under the previous ex parte system.[196]

In contrast, Nevada, another state where over 100,000 individuals were mistakenly disenrolled, informed the New York Times last month that it has already reinstated benefits for approximately 114,000 people.[197]

Additionally, attorneys across the country have noted that the special needs of disabled individuals were often overlooked as states conducted Medicaid eligibility reviews.[198] In Colorado, Texas, and Washington, D.C., the National Health Law Program, which advocates for low–income and underserved communities, has filed civil rights complaints with two federal agencies, alleging discrimination against people with disabilities.[199] While this organization has not yet filed a lawsuit in Florida, its attorneys report similar issues there.[200]

In Florida, the Department of Children and Families (DCF), which handles Medicaid eligibility, has a specialized team for processing applications for home health services.[201] According to Mallory McManus, the department's communications director, individuals with disabilities who were disenrolled from Medicaid were "properly noticed and either did not respond timely or no longer met financial eligibility requirements.[202]" McManus emphasized that individuals would have been contacted up to thirteen times by phone, mail, email, and text before their disenrollment was processed.[203] Despite this, many Floridians have reported that their benefits were cut off without any notification from DCF.[204]

The complexity of Medicaid reviews in Florida is partly due to the differing eligibility criteria for home health services compared to general Medicaid coverage.[205] Federal regulations give states more flexibility in determining financial eligibility for these services, resulting in higher income limits and different asset counting rules for home health services.[206]

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195 *Id.*
196 *Id.*
197 *Id.*
198 Daniel Chang, *How These Patients are Confronting the 'Unwinding' of Medicaid in Florida*, MIAMI HERALD (May 22, 2024), https://www.miamiherald.com/news/health–care/article288606104.html?tbref=hp.
199 *Id.*
200 *Id.*
201 *Id.*
202 *Id.*
203 *Id.*
204 Chang, *supra* note 198.
205 See *id.*
206 *Id.*

Analogous litigation—both for inadequate termination processes and civil rights complaints for individuals with disabilities—would be instrumental in safeguarding disenrolled Medicaid recipients elsewhere. This is especially crucial for individuals in Southern states facing larger coverage gaps, ensuring adherence to the Due Process Clause of the Fourteenth Amendment and the Medicaid Act across the nation.

VI. POLICY RECOMMENDATIONS FOR FLORIDA

Policy recommendations for the future can be divided into two categories: short–term policy recommendations and long–term policy recommendations.

A. *Short–Term Policy Recommendations*

The policies and systems in place in Florida created barriers to renewal for Medicaid enrollees. To overcome these barriers, there are several smaller–scale policy suggestions for state Medicaid offices to put into practice and consider in the future.

The Department of Children and Families should discontinue their standard template and create new templates that include more information alongside the reason codes, including calculations of how they determined Medicaid eligibility for each individual or family and other factors that were considered. Additionally, they *must* include addresses for DCF offices, telephone numbers, online resources, and specific instructions to request a fair hearing or appeal. Though this adds an initial administrative burden to DCF, these are necessary steps to ensure that the due process rights of Medicaid beneficiaries are not being violated. DCF is responsible for not just administering Medicaid, but doing so in a fair manner, ensuring that recipients receive the benefits they are entitled to. Until notices are individualized, they will continue to lead to confusion among Medicaid enrollees.

The Department of Children and Families and the federal government should increase public awareness of legislation likely to impact vulnerable individuals in the future. Doctors' offices, pharmacies, and other clinical settings should be required to post notifications. Ensuring that healthcare providers know about Medicaid redetermination, and can notify their patients, would be very beneficial.

The Department of Children and Families should provide multiple formats for renewal completion, communicate early and frequently.[207] Some participants reported that online renewal was a difficulty for them,

[207] Diana, Tolbert, Rudowitz & Corallo, *supra* note 63.

and they should be provided a mail–in or in–person option. Additionally, more communication utilizing multiple formats would lessen the number of erroneous terminations.

The state should provide more funding and training for Medicaid call–center employees. One of the major barriers enrollees faced involved long wait times at the call center, suggesting that employing more staff members may be necessary during major enrollment or disenrollment periods. Additionally, other enrollees reported difficulty receiving answers to their questions. Further training may be required to solidify the call center staff. Finally, DCF needs to ensure that all languages are represented in the call center to prevent disparities for non–English speaking Medicaid recipients.

B. Long–Term Policy Recommendations

The most impactful long–term policy that Florida could adopt is the acceptance of federal Medicaid expansion. The coverage gap exists in states that have not embraced ACA Medicaid expansion, leaving adults ineligible for Medicaid due to income exceeding eligibility limits and without access to subsidies in the ACA Marketplace, which are not available for those with incomes below the federal poverty level.[208] When the ACA was enacted, it was not anticipated that states could choose to opt out of Medicaid expansion, resulting in individuals below the poverty line ineligible for Marketplace subsidies.[209] Currently, forty states and DC have expanded Medicaid, but Florida is among the ten states that have chosen not to expand.[210]

Approximately 1.5 million individuals find themselves in the coverage gap across these ten states, with around 285,000 residing in Florida.[211] This population is disproportionately composed of people of color, constituting about sixty–two percent.[212] Nearly sixty percent of those in the coverage gap belong to families with employed members, and almost half are employed themselves, struggling with unaffordable or unavailable employer–based health insurance.[213] Moreover, over fifteen percent of individuals in the coverage gap have functional disabilities but do not

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208 Patrick Drake, Jennifer Tolbert, Robin Rudowitz & Anthony Damico, *How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?*, THE HENRY J. KAISER FAMILY FOUNDATION (Feb. 26, 2024), https://www.kff.org/medicaid/issue–brief/how–many–uninsured–are–in–the–coverage–gap–and–how–many–could–be–eligible–if–all–states–adopted–the–medicaid–expansion/.
209 *Id.*
210 *Id.*
211 *Id.*
212 *Id.*
213 *Id.*

qualify for Medicaid through a disability pathway.[214] Older adults, aged fifty–five to sixty–four, make up eighteen percent of the population in the coverage gap.[215] Addressing this coverage gap through Medicaid expansion is crucial for ensuring comprehensive healthcare access for these vulnerable populations.[216]

There are several compelling reasons why the expansion would be advantageous for Floridians. Numerous studies highlight overwhelmingly positive outcomes observed a decade after the introduction of Medicaid expansion in January 2014, with notable improvements in coverage being a key association.[217] As of May 2024, 3.87 million Floridians were covered by Medicaid or CHIP.[218] If the state accepted expansion, an additional 1.46 million Florida residents would also be covered.[219]

Moreover, expansion is associated with enhancements in access to healthcare and overall health outcomes, bringing economic benefits to both states and healthcare providers. Specific improvements in health outcomes span various areas, including access to care, cancer treatment and outcomes, management of chronic conditions, sexual health, reproductive health, and behavioral health.[220] Expansion is linked to a reduction in racial disparities concerning coverage and access.[221] Studies also show expansion leads to enhanced economic stability for individuals, decreased mortality rates, and positive economic impacts for providers, namely rural hospitals.[222]

The Florida economy is negatively impacted by non–expansion.[223] Florida left five billion dollars in federal funding on the table by not expanding Medicaid in 2023, plus additional funding through the American Rescue Plan Act (ARPA) provision.[224] Under the ARPA, states that newly embrace expansion qualify for an additional five percentage point increase in the state's traditional match rate for a duration of two years.[225] During this period, states are obligated to cover only ten percent of the cost associated with Medicaid expansion, with the federal government covering the remaining ninety percent.[226] An analysis by the

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214 *Id.*
215 *Id.*
216 *See id.*
217 *See id.*
218 *Medicaid eligibility and enrollment*, *supra* note 15.
219 *Id.*
220 Drake, Tolbert, Rudowitz & Damico, *supra* note 207.
221 *Id.*
222 *Id.*
223 *See Medicaid eligibility and enrollment, supra* note 15.
224 *Id.*
225 Drake, Tolbert, Rudowitz & Damico, *supra* note 207.
226 *Id.*

Kaiser Family Foundation indicates that all states yet to adopt expansion could experience a positive fiscal impact over a two–year span if they choose to implement the expansion.[227] Notably, South Dakota and North Carolina recently adopted expansion, with South Dakota estimated to benefit by $60 million, while North Carolina is projected to gain $1.2 billion.[228] According to an analysis by the Florida Policy Institute, Florida could save $200 million annually by expanding Medicaid.[229]

Finally, expansion has the potential to curb the rise in the uninsured population during the unwinding process. Amid the Covid–19 pandemic, all states witnessed substantial growth in Medicaid enrollment due to enhanced federal matching funds and state restrictions on disenrollment.[230] This surge has played a pivotal role in driving down the rate of uninsured individuals, despite economic hardship during the pandemic.[231] Expansion acts would serve as an effective measure to bridge the coverage gap and would lead to a reduction in the number of uninsured individuals in Florida.[232]

CONCLUSION

Individuals and families within the Medicaid program have a broad spectrum of health needs, and Medicaid plays a crucial role by providing essential coverage with minimal out–of–pocket costs. Given the absence of a more comprehensive, publicly funded healthcare system in the country, Medicaid is vital for many Americans. It is imperative for states, particularly Florida and other non–expansion states, to address the substantial barriers that lead to eligible individuals experiencing gaps in their Medicaid coverage. Just as important are efforts towards facilitating the enrollment of ineligible individuals into ACA Marketplace or other available plans.

An adjudication favoring the plaintiffs in the case of *Chianne D v. Weida* would represent a valuable initial step in rectifying the due process injustices precipitated by the Medicaid unwinding process. However, addressing the multifaceted challenges ahead requires a more

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[227] *Id.*

[228] *Id.*

[229] Jacob Wentz, *Medicaid Expansion Could Help Florida Overcome Budget Deficit, Advocate Says*, WUSF (Mar. 3, 2021, at 5:00 AM), https://www.wusf.org/health–news–florida/2021–03–03/medicaid–expansion–could–help–florida–overcome–budget–deficit–advocate–says (interviewing Anne Swerlick from the Florida Policy Institute).

[230] Drake, Tolbert, Rudowitz & Damico, *supra* note 207.

[231] *Id.*

[232] Wentz, *supra* note 228.

comprehensive and sustained effort in the future. The Department of Children and Families should adopt administrative changes to lessen the barriers enrollees face throughout the rest of the unwinding process, which would change Medicaid administration for the better and rectify long–standing issues. Long–term, the state of Florida legislature needs to adopt Affordable Care Act Expansion to minimize the coverage gap and improve the health of its residents.