A Guide for Florida Advocates

Choosing a Managed Care Plan for Medicaid Long-Term Care

How Is Florida Medicaid Changing its Long-Term Care Services?

From August 2013 through March 2014, the Florida Medicaid program is moving most consumers in long-term care programs to managed care. For individual consumers, the exact transition month will vary depending on where the consumer lives. Region-specific information is available in tables at the end of this guide.

What is Long-Term Care?

In the Florida Medicaid program, *long-term care* is care provided to consumers who cannot live independently. It includes nursing home care, assisted living facility care, and at-home care for consumers who otherwise would not be able to live in their own homes.

What Is Managed Care?

Under managed care, a consumer's health care services are provided by a single organization with a network of health care providers. This guide refers to these organizations as *managed care plans*. In most cases, the managed care plan receives a fixed monthly payment from the State for each enrollee, and in turn the plan accepts responsibility to provide health care as necessary to those enrollees.

The claimed advantage of managed care is that managed care plans are better able to coordinate a consumer's care, so that consumers receive better health care at an efficient price. A potential disadvantage, however, is that a managed care plan may have an incentive to deny care in order to cut expenses and increase profit.

Are All Florida Medicaid Services Being Moved to Managed Care?

Yes, with limited exceptions. Florida recently received permission from the federal government to provide long-term care services and most other Medicaid services (such as doctor's services and hospital care) through managed care. The switch to managed care for most consumers will occur first for long-term care services and then at a later date for other Medicaid-funded services.

How Is the State Notifying Consumers About the New Managed Care Program for Long-Term Care?

The State is sending notices to current Medicaid long-term care consumers who are being transferred to managed long-term care. The first notice is sent four months before the effective date in the consumer's region, and includes basic information about the program. A second notice, sent approximately two months before the effective date, will list the managed care plans that are available to the consumer, and explain the steps that a consumer should take in order to select a plan.

The specific dates applicable to each region are listed in tables at the end of this guide.

What Should a Consumer Do After Receiving the Notices?

The first priority is to make a timely choice of a managed care plan. After receiving the second notice, the consumer has approximately 30 days to choose a managed care plan. If the consumer fails to make a choice, he or she will be assigned to a plan.

How Can a Consumer Obtain Assistance in Choosing a Managed Care Plan?

Assistance is available from a Choice counselor by calling (877) 711-3622. One option is to request an in-person visit by a Choice counselor to discuss the options in more detail. Choice counselors do not work for the managed care plans; instead, they are required to give independent advice on choosing a managed care plan.

Independent assistance is also available from Florida's Aging and Disability Resource Centers. Contact information for these centers is listed in a table at the end of this guide.

Choosing a managed care plan also can be done on the Internet at www.flmedicaidmanagedcare.com.

Which Plans Are Available in Which Regions?

Seven plans have been approved for the long-term care program, but not all plans are approved in all regions. In most regions, consumers will have a choice of three or four plans. Region-specific information about plan availability is located in tables at the end of this guide.

Will a Consumer Be Able to Keep Seeing a Current Health Care Provider After Enrolling in a Plan?

Not necessarily. If a consumer wishes to keep seeing a current provider, it is extremely important for the consumer to enroll in a plan that includes that health care provider.

Until September 30, 2014, every plan will be required to offer a place in its network to every nursing home, hospice and aging service provider in the region. For these purposes, *aging service provider* means any service provider that previously provided services for adults with disabilities and older adults under 1) a Medicaid waiver for home and community-based services or 2) a community-service program administered by the Florida Department of Elder Affairs. The Medicaid waivers programs are the Aged and Disabled Adult Waiver, Assisted Living Waiver, Nursing Home Diversion Waiver, or Frail Elder Option. There are many community-service programs administered by the Department of Elder Affairs; two examples are Community Care for the Elderly and Home Care for the Elderly.

After September 30, 2014, these providers will be allowed to continue in the managed care plan unless they are excluded for failure to meet quality or performance standards.

Is It Possible for a Consumer to Avoid Managed Care for Medicaid-Funded Long-Term Care?

Yes, but only under limited circumstances and on a case-by-case basis. Although the state has not set specific standards for when a consumer can be exempted from enrolling in a managed care plan, it has given the following example: the consumer is receiving services from a nursing home or hospice that is not participating in any of the region's managed care plans.

To obtain an exemption, a consumer can contact the state's choice counselor, explaining why enrollment in managed care would be harmful to the consumer. After receiving the request, the state's choice counselor will pass the request on to the State. Then, the State will try to resolve the situation in a way that enables the consumer to receive necessary services from managed care, but as necessary can instruct the choice counselor to excuse the consumer from managed care.

If the State does not excuse the consumer from managed care and the consumer disagrees with this decision, he or she has the right to challenge the decision in a fair hearing. More information about such challenges is available in a companion consumer guide entitled, ***Appeals and Fair Hearings in Managed Long Term Care.***

After a Consumer Enters Managed Care, Will He or She Be Able to Keep Receiving the Same Long-Term Care Services?

Initially yes, but the right to receive the same services does not last indefinitely. After enrollment in a plan becomes effective, the plan must continue previously-authorized services with the same providers, until a new assessment and care plan have been completed, and the care plan is ready to be implemented. This right to continue the same services, however, does not last beyond 60 days, even if for some reason the new care plan has not been prepared by that time.

In most cases, the switch to the new care plan should be accomplished long before the 60-day maximum. Plans are required to develop a care plan within five days of a consumer's enrollment (seven days if the consumer lives in a nursing home).

If at the time of transition a consumer is receiving care through any of the following pre-existing waiver programs — Aged and Disabled Adult Waiver, Assisted Living Waiver, Nursing Home Diversion Waiver, or Frail Elder Option — the waiver case manager will assist in the transition to managed care.

Can a Consumer Begin Receiving Services While the State Is Still Determining Whether He or She Qualifies Financially for Medicaid?

Yes, although the payment and eligibility procedures differ depending on whether the consumer 1) is living in a nursing home, or 2) is receiving long-term care at home or in an assisted living facility. In either case, the consumer must be assessed to need nursing home care, or an

equivalent level of care provided in another setting, as determined through the State's CARES assessment process.

If a consumer resides in a nursing home, he or she should apply for Medicaid after spending down savings below Medicaid eligibility levels. If found eligible, the consumer chooses a managed care plan for covering the nursing home care into the future. Any retroactive coverage (going back to as many as three months before the month of application, if the consumer was eligible during that time) is covered by the State under typical Medicaid procedures.
If a consumer lives at home or in an assisted living facility, the consumer can receive Medicaid-funded long-term care services under the Medicaid-pending category once an application has been filed and he or she has been determined by the CARES assessment to meet the program's

level of care requirements. The services are provided by a managed care plan selected by the consumer. The category is termed *Medicaid-pending* because the consumer's financial eligibility has not yet been determined. The consumer can be liable to the managed care plan for the cost of services if he or she subsequently is determined financially ineligible for the month or months in question.

Enrolling in a plan on Medicaid-pending status makes good sense for consumers who are certain that they are financially eligible; once they are formally determined to be financially eligible, the plan will go back and cover all services provided during the Medicaid-pending period. Medicaid-pending status, however, may not be advisable for a consumer who may not be financially eligible. If the consumer ultimately is determined not eligible financially for Medicaid, he or she can be personally responsible for charges incurred during the Medicaid-pending period.

Can a Consumer Change Health Plans After Making an Initial Choice?

Yes, but only under certain conditions. Within the first 90 days after initial enrollment, a consumer can switch enrollment to any other plan offered within the region; after that, however, transfers can only be made once a year during an annual 60-day open enrollment period (unless the consumer has good cause for changing, as explained below). A consumer in the Medicaid-pending category, however, cannot change plans until the State has determined financial eligibility and approved the application.

With good cause, however, transfer to a different plan can be made at any time. Here are some examples of *good cause*:

- The health plan provides poor quality of care.
- The plan has failed to provide the consumer with services that should be included in his or her coverage.
- The consumer needs to switch plans in order to continue receiving services from an historical service provider.

- In the plan, the consumer cannot obtain providers experienced with his or her health care needs.
- The consumer was enrolled in the health plan by mistake.

Remember, these are examples only; there are many other situations that might be considered to be good cause to transfer to another health plan. Other examples are listed in section 59G-8.600 of the Florida Administrative Code.

How Should a Consumer Seek Permission to Transfer from One Plan to Another Outside the Open Enrollment Period?

Outside the annual open enrollment periods, as explained above, transfer is only allowed when the consumer can show good cause. The consumer should first request transfer by filing a request with the State or the choice counselor. The request is deemed automatically approved if a decision on the request is not made by the first day of the second month following the month of the request. If a request is denied, the consumer can appeal by requesting a fair hearing. More information is available in a companion consumer guide entitled, ***Appeals and Fair Hearings in Managed Long-Term Care***.

Florida's Eleven Regions

Region	Counties
1	PENSACOLA AREA -- Escambia, Okaloosa, Santa Rosa, and Walton
2	TALLAHASSEE AREA -- Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
3	GAINESVILLE AREA -- Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
4	JACKSONVILLE AREA -- Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
5	ST. PETERSBURG AREA -- Pasco and Pinellas
6	TAMPA AREA -- Hardee, Highlands, Hillsborough, Manatee, and Polk
7	ORLANDO AREA -- Brevard, Orange, Osceola, and Seminole
8	FORT MYERS AREA -- Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
9	PALM BEACH AREA -- Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
10	FORT LAUDERDALE AREA – Broward
11	MIAMI AREA -- Miami-Dade and Monroe

Timeline for Notices and Implementation

Region	1st Notification Letter	2nd Notification Letter	Effective Date of Managed Care
1	Nov. 1, 2013	Jan. 20, 2014	March 1, 2014
2	July 1, 2013	Sept. 16, 2013	Nov. 1, 2013
3	Nov. 1, 2013	Jan. 20, 2014	March 1, 2014
4	Nov. 1, 2013	Jan. 20, 2014	March 1, 2014
5	Oct. 1, 2013	Dec. 16, 2013	Feb. 1, 2014
6	Oct. 1, 2013	Dec. 16, 2013	Feb. 1, 2014
7	April 1, 2013	June 24, 2013	Aug. 1, 2013
8	May 1, 2013	July 22, 2013	Sept. 1, 2013
9	May 1, 2013	July 22, 2013	Sept. 1, 2013
10	July 1, 2013	Sept. 16, 2013	Nov. 1, 2013
11	Aug. 1, 2013	Oct. 21, 2013	Dec. 1, 2013

Long-Term Care Plans By Region

REGION	American ElderCare	Amerigroup	Coventry	Humana	Molina Healthcare	Sunshine State Health Plan	United Healthcare
1	x					x	
2	x						x
3	x					x	x
4	x			x		x	x
5	x				x	x	x
6	x		x		x	x	x
7	x		x			x	x
8	x					x	x
9	x		x			x	x
10	x	x		x		x	
11	x	x	x	x	x	x	x

Aging and Disability Resource Centers

Region	Name	Address	Telephone Number
1	Northwest Florida Area Agency on Aging	5090 Commerce Park Circle Pensacola, FL 32505	(850) 494-7101
2	Area Agency on Aging for North Florida	2414 Mahan Drive Tallahassee, FL 32308	(850) 488-0055
3	Elder Options	100 SW 75th St., # 301 Gainesville, FL 32607	(800) 963-5337
4	elderSource	4160 Woodcock Drive Jacksonville, Fl 32207	(888) 242-4464
5	Area Agency on Aging of Pasco-Pinellas	9549 Koger Blvd, Gadsden Building, Suite 100 St Petersburg, FL 33702	(800) 963-5337
6	West Central Florida Area Agency on Aging	5905 Breckenridge Parkway Tampa, FL 33610	(800) 96-ELDER (35337)
7	Senior Resource Alliance	988 Woodcock Road #200 Orlando, FL 32803	(407) 514-1800
8	Seniorchoices of Southwest Florida	15201 N. Cleveland Ave, North Fort Myers, FL 33903	(239) 652-6900
9	Your Aging Resource Center	4400 North Congress Ave. West Palm Beach, FL 1100 SW St. Lucie West Boulevard, #103	(866) 684-5885

		Port St. Lucie, FL 34986	
10	Aging and Disability Resource Center of Broward County	5300 Hiatus Road Sunrise, Florida 33351	(954) 745-9779
11	Alliance for Aging	760 NW 107 Ave., Suite 214 Miami, Florida 33172	305-670-HELP (4357)

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