



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

**FOR IMMEDIATE RELEASE**  
December 13, 2013

**Contact:** AHCA Communications Office  
[AHCACommunications@ahca.myflorida.com](mailto:AHCACommunications@ahca.myflorida.com), 850-412-3623

## **SETTING THE RECORD STRAIGHT: Georgetown University Brief Misleading about Long-term Care Transition**

The Georgetown University Brief released earlier this week omits critical program-specific details that provide context for some outcomes and in some places is contradictory. It cites stakeholders who place unnecessary blame on the State for recipients who did not open their mail or report a complaint, but expected responsive action from the Medicaid program. Further, it makes statements about what may have been found to be successful elsewhere, but fails to mention that Florida already carried out the best practice.

While the brief includes some positive remarks about Florida's experience, like the Agency's good communication about policies and the ability to make adjustments based on our phased-in approach, it fails to provide many of the overwhelming successes related to the Long-term Care program implementation, for example, the rigorous continuity of care provisions and the success achieved with regard to enrollees remaining in their current residence, including nursing home and assisted living facilities. Other claims and clarifications are provided below.

**Claim:** "Almost all of the beneficiaries who use long-term care services—95 percent—are dually eligible for the Medicaid and Medicare programs and therefore have coverage for most acute medical services as well as pharmacy benefits through the Medicare program. Thus, this vulnerable population with complex needs will have multiple coverage decisions to make, which will likely be confusing and pose challenges to achieving effective service continuity and coordination."

**Fact:** Regardless of the transition to Statewide Medicaid Managed Care (SMMC), the dually eligible population would continue to receive some benefits from Medicaid and some from Medicare. The SMMC program and its two parts—Long-term Care (LTC) and Managed Medical Assistance (MMA)—will afford dually eligible recipients a new opportunity for care coordination not previously available.

Recipients eligible for both the LTC and MMA will have the option to choose a comprehensive plan (one that provides LTC and MMA services) in all regions except 1 and 2. In addition, many of the MMA plans (all the HMOs) selected to provide services also operate Medicare plans, and will therefore provide an enhanced opportunity for coordination of Medicare and Medicaid health care services. At the time of enrollment and within the enrollment materials, individuals will receive information regarding the availability of comprehensive plans in their region. Further, via the new Long-term Care program, every recipient has a case manager whose specific job is to help recipients with their needs, questions and care delivery.

**Claim:** "The new Long-term Care program maintains the Medicaid entitlement to nursing care but sets a cap of 36,795 slots for community based services."



**Fact:** While the State currently has waiver authority for 36,795 community-based services slots, that number is NOT a hard cap. It is standard protocol to have waiver authority for a set number of community-based services slots, and to amend the waiver whenever funding for additional slots becomes available. Additional funding for waiver slots was provided for the 2013-2014 fiscal year and people are being enrolled in those slots now. Before the end of the fiscal year, the Agency will amend the waiver to increase the number of slots to reflect this increased enrollment.

**Claim:** “Some beneficiaries received notices for the wrong region with the wrong enrollment timeframe... For the population receiving Medicaid long-term services and supports, living situations change as needs or economic circumstances change or as better alternatives become available. Thus, addresses on file do not always match beneficiaries’ current place of residence.”

**Fact:** Virtually every recipient was notified in the correct timeframe. For the miniscule segment of recipients who were not, it was because of incorrect addresses on file, which is why the State consistently reminds recipients to notify the State if they have a change of address. Maintaining correct address records is an on-going effort and not specific to the SMMC program transition.

**Claim:** “There was no help for beneficiaries who did not receive notices or did not report problems.”

**Fact:** Anyone has the ability to file a complaint online or over the phone and is encouraged to do so if they experience problems. The Agency established a triage system to ensure the most critical issues are attended to first. The Agency and the Department of Elder Affairs proactively called thousands of recipients to ensure that they understood the program and were not experiencing breaks in services.

**It is imperative that recipients or their caretakers report a problem if they would like assistance or resolution.** The online complaint form can be accessed through the following link: [http://apps.ahca.myflorida.com/smmc\\_cirts/](http://apps.ahca.myflorida.com/smmc_cirts/) or by calling the local Medicaid Office.

**Claim:** “...stakeholders report that among the population using long-term care services and supports, some beneficiaries don’t open, read, or understand mail.”

**Fact:** Similar to a private insurance company sending important information to their members, letters from the Agency to Medicaid recipients are sent to the address on file and should be read upon receipt. If a recipient does not understand the content of any letter, they should contact their local Medicaid office for support or the phone number in the letter. The Agency takes seriously our responsibility to make the content as simple as possible; letters are often shared with advocates for input before release and are written in plain language.

As noted later in the Georgetown brief, “Stakeholders report that enrollment letters are well written and present information in a simple, useful manner.”

**Claim:** “To make informed decisions, beneficiaries and those who assist them need complete information about MCO characteristics.”

**Fact:** The certified choice counselors are available to discuss the different enhanced benefits and provider networks with recipients; recipients only need to provide their preferences and the choice counselor will help them make an informed choice. The choice counseling tool, HealthTrack, contains information about all the long-term care plans, their provider networks and the extra benefits they offer.

As a standard, all long-term care plans provide the same basic services at the minimum required levels; some plans offer extra benefits. All plans are required to have an adequate network of all providers, but not all providers are in all plans.

**Claim:** “[providers] were concerned about payments for services provided during the 60-day transition period when they were obligated to continue providing services to current clients...Some providers noted that they could not assure clients of continuity of care because they had not yet completed contracts.”

**Fact:** The Agency, along with sister agencies, conducted an aggressive outreach campaign to notify providers they will be paid regardless of their contract status with plans. Activities included sending letters to specific provider groups, calls to providers, electronic provider alerts and provider-focused trainings.

As noted later in the Georgetown brief, “Stakeholders observed that AHCA has done a good job of communicating policies regarding service continuity to plans and providers.”

**Claim:** “‘High-touch’ personalized communication including in-person, one-on-one counseling and phone support were found to be the most effective strategies for engaging beneficiaries when California conducted mandatory enrollment of seniors and people with disabilities into managed care.”

**Fact:** The Agency’s outreach has been both high touch and personalized. The Agency offered group education and one-on-one choice counseling sessions to every nursing home and the majority of assisted living facilities in the State in English, Spanish and Creole. In addition, the call line is open from Monday-Thursday 8am-8pm and Friday from 8am-7pm and is available in over 200 languages. Home visits are also available upon request and nearly 1000 have been completed to date. Choice counselors also make visits to recipients who have not made a voluntary selection and either do not have a phone number on file or a functioning phone number.

**Claim:** “...the new program requires Diversion plans to help beneficiaries with the transition to the new programs. But Diversion plans that did not receive contracts are not obligated to operate until the transition date in their region.”

**Fact:** Individuals who are currently enrolled with a Diversion plan at the time LTC is being implemented in their region will transition into the new program. The State has required existing Diversion plans and case management agencies (those who provide case management services through the fee-for-service long-term care waivers) to engage in many activities in advance of a regional roll out that are designed to contribute to maintaining the enrollees’ service levels and satisfaction. These activities include:

- Providing all enrollee care plans and service authorization information to the Agency for dissemination to the recipient’s new LTC plan so the new plan can use that information to continue providing services to the new enrollee without interruption;
- Communicating with their network providers regarding the requirements for the existing network to deliver services for up to 60 days or until the new LTC plan has notified the provider that a new provider is in place;
- Identifying high risk enrollees to prepare any special handling necessary;
- Ensuring that enrollees’ level of care documentation is current; and
- Ensuring that enrollees’ Medicaid eligibility is current.

**Claim:** “Strong ombuds programs are elements of quality assurance in many states...Florida’s ombuds program... likely will not play an important role in the Long-term Care program.”

**Fact:** The Florida Long-Term Care Ombudsman Program has a very important role in Florida’s managed care transition. The local ombudsmen serve as the primary contact for responding to concerns from plan members who are in assisted living facilities, adult family care homes and nursing homes. As part of the Independent Consumer Support Program approved by CMS, the Office of the LTC Ombudsman has prepared training and referral information and is collecting and reporting data on activities that involve SMMC plan members. Though not involved in choice counseling or care planning, the Office of the ombudsman advocates for residents’ rights and welfare, works with the grievance and appeal process of each plan and investigates facility issues as they arise.

**Claim:** “Cost reductions and quality improvements are two important goals for the new Long-term Care program, yet the program is designed to reward MCOs financially for reducing costs, but not specifically for improving quality.”

**Fact:** Long-term care plans that exceed Agency-defined quality measure targets will be eligible for a 1% add-on to an Achieved Savings Rebate. Plans that do not achieve defined targets for quality measures may be subject to liquidated damages and/or sanctions.

*The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida’s Medicaid program, licenses and regulates more than 45,000 health care facilities and 37 health maintenance organizations, and publishes health care data and statistics at [www.FloridaHealthFinder.gov](http://www.FloridaHealthFinder.gov). Additional information about Agency initiatives is available via [Facebook](#) (AHCAFlorida), [Twitter](#) (@AHCA\_FL) and [YouTube](#) (/AHCAFlorida).*

###