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**FOR IMMEDIATE RELEASE**

September 4, 2014

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**SETTING THE RECORD STRAIGHT:  
AP Article Omits Important Facts about Managed Medical Assistance Rollout**

**Here are the facts:**

- There are no co-payments in Medicaid for children who are fully eligible for Medicaid, and most MMA plans have waived co-payments for fully eligible adults. The \$40 copayment described in the story is not consistent with full Medicaid coverage. It is consistent with Obamacare coverage and/or private health insurance (such as through an employer). Again, there are no co-payments for fully Medicaid eligible children.
- The Agency has worked extensively with providers and the health plans to ensure that recipients experience no disruption in care.
  - The plans must honor prescheduled appointments for ongoing care for up to 60 days after transition and must pay the enrollee's provider at the previous rate they were receiving for the enrollee's care for at least 30 days after transition. Plans must pay the provider for services rendered even if the patient's provider is not under contract with the plan.
  - Based on the Agency's knowledge, it has been rare for a provider to refuse to provide services during the continuity of care period, as described in the AP story. Nevertheless, a provider may choose to cancel appointments despite the fact that the Agency has guaranteed continuity of care payments.
  - The Agency has communicated extensively to providers, advocates and other interested parties regarding this continuity of care period through provider alerts, provider webinars, presentation to various advocacy and provider groups, and through numerous press releases.
- Any recipients who are required under the SMMC program to enroll in an MMA plan for Medicaid services would have received three letters prior to the plan enrollment taking effect (a pre-welcome letter, a welcome packet with information on available plans, and a reminder letter) letting them know they should select a health plan to provide all Medicaid services, and if they do not, they will be assigned to the plan listed in the letter. If the recipient wants the plan that is listed in their letter, no action on their part is necessary.
  - Medicaid recipients began receiving these letters almost four months before the date of their enrollment into a plan. The letters encourage them to contact our Choice Counselor by Internet or by phone to make a plan choice, if they were not



happy with the health plan that they have been assigned.

- Whenever available, the Agency assigned recipients to a health plan with which they had a prior relationship.
- In addition, after enrollment occurs, recipients, including parents of children, have 90 days to choose a different plan if they are not happy with their current plan for any reason.
- Transportation to Medicaid covered services is a required benefit and the plans will provide transportation at no additional cost to recipients.
- The Agency has not received any complaints that we can identify from the providers/recipients mentioned in the AP article. Complaints of the nature described would have been responded to within 24 hours. Complaints can be entered via the Agency's [issue hub](#). Recipients and providers can also contact their local Medicaid field office by phone to report issues and receive assistance.
- The Agency has held numerous public meetings and done extensive outreach regarding the Managed Medical Assistance (MMA) program.

*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 34 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).*

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