Q &A for Advocates:

How Medicaid Is Changing in Florida for Those Needing Nursing Home, Assisted Living Facility, and At-Home Care

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What Is Managed Care?

In traditional Medicaid, a consumer can seek care from any health care provider (such as a doctor) who is Medicaid-certified. In managed care, however, the care is coordinated by a *managed care plan* which is sometimes called a health maintenance organization (HMO) or provider service network. In most cases, the health care must be provided by a health care provider who is part of the plan's provider network.

How Does Florida Medicaid Use Managed Care?

For most populations, the Florida Medicaid program requires consumers to receive Medicaid-funded health care through managed care. The Medicaid program pays the managed care plan a fixed amount for each Medicaid consumer in that plan, and then the plan is responsible for providing the health care that the consumer needs. Theoretically, the managed care plan will coordinate health care effectively so that the consumer receives better care with less expense for the state.

Are All Medicaid Services in Florida Provided Through Managed Care?

Yes, with limited exceptions. Year to year, Florida's Medicaid program is expanding its managed care program to cover more people and more types of services.

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 for long-term care services before it happens for other Medicaid-funded services.

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.

Which Medicaid Consumers Are Eligible to Receive Long-Term Care Services?

Long-term care services are available only to consumers who have care needs that would qualify them for nursing home care. These consumers have a choice of receiving long-term care services in a nursing home, an assisted living facility, or at home. The availability of services in an assisted living facility or at home is limited by an enrollment cap.

The need for nursing home care is measured through an assessment performed by the Comprehensive Assessment and Review of Long-Term Care Services (CARES) Unit of the Department of Elder Affairs. A registered nurse and/or assessor performs client assessments which are then reviewed by a physician or registered nurse who in turn determines the appropriate level of care. Under federal law, the CARES Unit must perform assessments for each person who seeks Medicaid reimbursement for nursing home care or for home and community-based services, and upon request, may perform assessments for persons paying privately for care.

More information about CARES and assessments is available at the Elder Helpline at (800) 963-5337.

Which Current Medicaid Consumers Are Being Moved to the Long-Term Care Managed Care Program?

A move to managed care will be required for Medicaid consumers currently living in nursing homes, or those receiving services under any one of the following programs: Aged and Disabled Adult (A/DA) Waiver, Assisted Living Waiver, Nursing Home Diversion Waiver, and Frail Elder Option (Miami-Dade County only).

Enrollment in managed long-term care is not required, but is an option, for consumers in the following programs: Developmental Disabilities Waiver, Traumatic Brain and Spinal Cord Injury Waiver, Project AIDS Care Waiver, Adult Cystic Fibrosis Waiver, Familial Dysautonomia Waiver, Model Waiver, and the Program of All-Inclusive Care for the Elderly (PACE).

What Are the Financial Eligibility Standards for Medicaid Managed Care?

A move to managed care has not changed the applicable financial eligibility standards for long-term care services. In general, a single person must have no more than $2,000 in available assets

(not counting a house, car, etc.) and a gross monthly income of no more than $2,130 (for 2013). If a consumer is married, the spouse may have countable assets up to $115,920 (for 2013) in order to allow him or her to have the ability to pay for living expenses.

Will Services Be Available for Every Medicaid Consumer Who Needs Long-Term Care Services?

No, there is an enrollment limit for residents of assisted living facilities and consumers residing at home. When applying for these services, the consumer will be placed on a waiting list unless he or she already was approved for Medicaid long-term care while residing in a nursing home. Nursing home services are not subject to an enrollment limit.

To learn more about eligibility or to begin the application process, consumers can call the Elder Helpline at (800) 963-5337.

Does This Change to Managed Long-Term Care Affect a Consumer's Medicare Coverage?

No, this change involves Medicaid, not Medicare. For persons eligible for Medicaid and Medicare, the change to managed long-term care will not affect Medicare benefits, since Medicare generally provides little coverage for long-term care services.

When Is Long-Term Care Being Moved to Managed Care?

The start date varies depending on where a consumer lives. The Medicaid program has divided the state into eleven regions. Region Seven, which includes four counties in the Orlando area, is the first region with managed long-term care, with managed care taking effect on August 1, 2013. Start dates for all eleven regions are summarized in the tables at the end of this guide.

How Is the State Notifying Consumers About the New Managed Care Program?

The State is sending notices to current Medicaid consumers who are being transferred to managed long-term care. The first notice will be sent four months before the effective date, and will include basic information about the program. A second notice, sent approximately one and a half 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 the tables at the end of this guide.

Consumers can obtain information on plans and the enrollment process by speaking to a choice counselor at (877) 711-3662.

What Should a Consumer Do After Receiving the Notices?

The consumer should take steps to choose the plan that best meets the consumer's needs. The consumer should not ignore the notices: if the consumer does not make a timely choice, the Medicaid program will automatically assign the consumer to a managed care plan, without any input from the consumer.

It is very important for the consumer to make an informed choice. For example, the consumer will want to choose a plan that includes the consumer's current health care providers (assuming that he or she wishes to keep current providers).

These issues are discussed in more detail in a separate consumer guide entitled, ***Consumer Tips for Enrolling 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

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