



# Family Care Council Florida

Agency for Persons with Disabilities

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Vice Chairperson:

Betty Kay Clements

Past Chairperson:

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DRAFT

## FCCF Managed Care Talking Points

Area Chairs:

Area 1

Lynn Carper

Family Care Council Florida (FCCF) supports the Agency for Persons with Disabilities (APD). It is FCCF position that APD merits the time to fully implement legislative mandates.

Area 2

Vacant

Because APD's focus is solely on developmental disabilities (DD), basic infrastructure was required and has been accomplished:

Area 3

Shelly Voelker

- Prior Service Authorization for waiver services. Prior to APD, there was no uniform approval process for services.
- Implementation of a rate structure. Prior to APD, provider rates were not the same in all areas of Florida.
- Family and Supported Living Waiver (FSL) This waiver allows more people to receive services, using a dollar limit.

Area 4

Vacant

SunCoast Region

Beverly DeStories

Area 7

Jeannie Forthuber

Currently, with APD managing, controlling, and providing services, any savings will go directly to serving individuals on the Medicaid wait list. With managed care, any savings will go directly to the shareholders of the managed care provider.

Area 8

Maria Eash

Area 9

Maryellen Jones

FCCF opposes any proposal that moves APD and the waiver services into a managed care program:

Area 10

Belkis Almeida  
Jean Sherman

- 1. HMOs will be experimenting in Florida on individuals with DD to provide all their services. (No other state has tried what is being proposed in Florida)**

Area 11

Margarita Montalvo

Efforts to be a national leader and quickly enroll large numbers of people with DD into managed care runs the risk of not producing expected savings or reducing the quality of care currently received.

Area 12

Phil Pearson

Area 13

Betty Kay Clements

In a desperate attempt to succeed, HMOs will have to shift Medicaid resources from long-term care to acute care services, behavioral services to psychotropic drugs, and self-determination to status quo.

Area 14

Laura Tacinelli

Area 15

Todd Decker

*The mission of the Family Care Council Florida is to advocate, educate, and empower individuals with developmental disabilities and their families, partnering with the Agency, to bring quality services to individuals for dignity and choice.*

## **2. HMOs have experience in serving medical patients and have no experience supporting individuals with developmental disabilities (DD)**

- HMOs do not understand the Medicaid Waiver service system for persons with DD and cannot be expected to successfully manage a foreign program.
- Services required are beyond the traditional definition of medical care, but are critical for people with DD.
- The DD population criteria for services are significantly different than other populations. An example, a companion for an elderly patient might mean house sitting with the individual. A companion for people with DD will be expected to go out into the community and help interact with others, including volunteer work.

## **3. HMOs do not have to adhere to the Medicaid waiver service handbook**

Once the Agency for Health Care Administration (AHCA) approves an HMOs plan for services and some type of quality assurance provisions, HMOs do not have to worry at all about handbook requirements. They would not be able to make a profit if they had to comply with current standards.

## **4. HMOs can “opt out” of providing services to individuals with developmental disabilities (DD)**

- HMOs are only successful when they have more “healthy people than “sick” people, in order to balance the risk of providing needed services. They may choose to opt out when this balance is not met.
- The medical model of managed care relies on saving money by better management of services, and “curing” or “fixing” the problem, thereby reducing the needs and saving money. Since individuals with DD cannot be “cured” or “fixed”, this model cannot work unless services and supports are reduced and needs not met.

## **5. HMOs will add additional administrative costs, taking away from services**

Administrative costs of such a complex program, with the comprehensive and varying needs of individuals with DD, cannot be met without reducing services.

- HMOs will not be able to pay providers their current rate structure, pay their administrative overhead, and provide the same quality and choice of services.
- In the Arizona system, service/care is only authorized for 90 days at a time; every person must be re-certified for each service every 90 days. If not re-certified (for whatever reason) the service will stop, and must be requested and approved anew.

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## **6. HMO provider rates will be prohibitive to attract and retain quality providers**

Provider rates for DD services in Florida are currently below the national average.

- Many current providers solicit supplemental funding through fundraisers, donations, and community outreach to offset expenses.
- Flexibility of the provider and scope of services are critical. Each individual is different and must have services tailored to their own needs.

## **7. HMO provider network selection will be very limited - Residential Habilitation (group homes); Supported Living Coaching; Supported Employment Coaching; Personal Care Assistance; Physicians; Specialists; Therapists; etc.**

There will be no access for solo or independent providers unless they join a big agency. DELMARVA quality control continues to show the value of independent/solo providers in Florida as well as agency providers. Choice is not one large agency over another. Eliminating solo/independent providers will jeopardize quality and choice for services.

## **8. HMOs primary focus will be on cost reduction and not services**

### **a. HMOs must make a profit for their shareholder (s)**

HMOs are big business with their stock traded on the New York Stock Exchange. Investors want to see a return on their dollar and they are getting that. WellCare's stock price has tripled since it started trading in July 2004. (Wall Street Journal Nov.15,2006) HMOs make money and lots of it. What is good for shareholders is bad for patients.

### **b. HMOs will select the least expensive service/treatment to save money**

HMOs seek to save money by eliminating unnecessary care and paying for preventive treatments. The determination of what is unnecessary would most likely be made by a professional in the medical field. Would supportive living coach ever be a necessary service in the eyes of a medical professional? The very services that provide access to community living and supports, as well as purpose in the lives of individuals with DD on the waivers, are at great risk as being deemed unnecessary care.

Individuals with developmental disabilities already have the disability so there is no preventive treatment and the disability is a life long disability.

### **c. HMO providers will receive a reduced reimbursement for services**

HMOs receive a per-patient premium rate X% below what it would cost the state. HMOs have an incentive to keep their cost under the premium in order to have a saving.

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