Committee on Health Regulation

CS/HB 7109— Medicaid

by Appropriations Committee; Health and Human Services Committee; and Rep. Schenck (CS/CS/CS/SB 1972 by Budget Committee; Budget Subcommittee on Health and Human Services Appropriations; Health Regulation Committee; and Senators Negron, Gaetz, Garcia, and Hays)

The bill is designed to conform certain provisions of existing Medicaid law to CS/HB 7107 and authorizes a number of immediate changes to the Medicaid program. The bill also repeals numerous provisions on future dates to conform general Medicaid provisions to the full implementation of the Medicaid managed care program. The bill becomes effective only if CS/HB 7107 is enacted.

Persons with Developmental Disabilities

- The bill expands eligibility for the home and community-based waiver program for persons with developmental disabilities to include individuals diagnosed with Down Syndrome.
- If the Agency for Persons with Disabilities continues a deficit during fiscal year 2012-2013, the agency must submit a plan to the Legislature for a redesigned waiver program as an alternative to current waiver models. The new program model must include specific elements (e.g., budget predictability and redesigned support coordination services) and be approved by the Legislature before implementation on July 1, 2014.

Medicaid Program

- The bill expands the disqualification for receiving Medicaid benefits from 5 to 10 years for a person found to have committed Medicaid fraud.
- The Agency for Health Care Administration (AHCA) is directed to request federal approval to develop a system to require parents with household incomes greater than 100 percent of the federal poverty level to pay premiums or other cost sharing methods for home and community-based services for their developmentally disabled children.
- The AHCA is directed to request federal approval to require Medicaid recipients to pay $100 co-payments for nonemergency services provided in a hospital emergency department.
- The bill provides that Medicaid shall not pay for psychotropic medications for a child unless specifically authorized by the parent or guardian.
- The AHCA is directed to develop a process to enable a recipient with access to employer-sponsored coverage to opt-out of all Medicaid managed care plans and use Medicaid financial assistance to pay the recipient's share of the cost for the employer-sponsored coverage. The AHCA is also directed to seek federal approval to enable recipients with access to other insurance or related products that provide access to health care services, including products available under the Florida Health Choices program or any health exchange, to opt-out. The amount of financial assistance provided for any such recipient

may not exceed the amount the Medicaid program would have paid to a Medicaid managed care plan for that recipient.

Medicaid Managed Care

- The AHCA is required to develop uniform accounting and reporting requirements for Medicaid managed care plans. The plans must begin reporting their medical and non-medical costs to the AHCA. This information must be made public will help ensure that plans are providing adequately managed, patient-centered care.
- Plans will be given advance notice and an opportunity to comment on any potential rate adjustments. The AHCA will perform a simulated rate-setting exercise prior to making rate adjustments, the results of which must be posted on the AHCA's website for 45 days.
- The current option for Medicaid recipients in one of the five Medicaid Reform pilot counties to use their Medicaid premium to purchase employer-sponsored insurance is permitted statewide. This option is further expanded (subject to federal approval) by allowing recipients to use their Medicaid dollars to pay for other insurance or products that may be available to them.
- The AHCA is authorized to exempt recipients from managed care on a case-by-case basis for specialized or unique, time-limited, and ongoing care that patients may be receiving at the time they enroll in Medicaid.
- The AHCA is required to contract with prepaid dental plans until Medicaid managed care is fully implemented in all regions under CS/HB 7107.

Hospital Rates

- The AHCA is directed to implement a methodology for establishing Medicaid reimbursement rates for each hospital based on allowable costs. The rates will be set once annually and the reconciliation period is limited. This process is designed to provide budgetary certainty and administrative simplification.
- The AHCA is directed to develop a plan to convert inpatient hospital rates to a prospective payment system that uses diagnosis related groups (DRG) and assigns a payment weight.
- The AHCA must submit the Medicaid DGR plan to the Governor and Legislature by January 1, 2013.

Provider Service Networks

- The same payment requirements applicable to provider service networks (PSNs) in the five Medicaid Reform pilot counties are applied to all PSNs statewide in order to prepare them for expansion of managed care under CS/HB 7107.
- PSNs may still be fee-for-service for a period of time, but specific requirements are established for shared savings and guidelines are defined for a reconciliation process that determines shared savings.

- A prepaid PSN that applies for and obtains a health care provider certificate from the AHCA, meets the surplus requirements for health maintenance organizations (HMOs) under the Insurance Code, and meets all other applicable requirements relating to the regulation of health maintenance organizations (HMOs), may obtain a certificate of authority under the Insurance Code relating to HMOs. A certified PSN is granted the same rights and responsibilities as a certified HMO. The bill creates an exception in the Insurance Code's solvency requirements for PSNs to specify that a PSN seeking a certificate of authority must meet the bill's surplus requirements instead of those under existing law.

MediPass

AHCA is directed to contract with a single PSN to function as a third party administrator and managing entity for the MediPass program in all counties with fewer than two prepaid plans. The contract will expire when the managed care program is fully implemented under the provisions of CS/HB 7107.

Medically Needy Program

- The AHCA is directed to immediately contract with a PSN to coordinate and manage the care of the Medically Needy. Such recipients will be continuously enrolled for a period of 6 months. The enrollees will pay their share of costs as a monthly premium and enrollees will be given a 90 day grace period for late payments of their share of costs.
- The Medically Needy contract with the PSN will expire when the managed medical assistance program is effective statewide under CS/SB 7107.
- Additionally the AHCA is directed to develop a plan for transitioning Medically Needy recipients into the managed medical assistance program. The AHCA is to immediately seek any federal authorization needed for the implementation.

Tort Reform

- To encourage greater participation by medical practitioners in the Medicaid program, the bill creates limitations on noneconomic damages for negligence of a practitioner providing services and care to a Medicaid recipient.
- Noneconomic damages may not exceed $300, 000 per claimant unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner, defined as acting in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.
- An individual practitioner is not liable for more than $200,000 in noneconomic damages, regardless of the number of claimants, unless a claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner.

- For the bill's limitations on noneconomic damages, the term "practitioner," in addition to practitioners included in the definition under s. 766.118(1), F.S., includes hospitals, ambulatory surgical centers, and mobile surgical facilities.

The Department of Elder Affairs

- The Department of Elder Affairs (DOEA), which currently manages waivers related to elder care, will no longer manage the waiver programs once managed care is implemented statewide under CS/HB 7107. However, the DOEA will still play key roles in transitioning their clients to managed care plans as the plans are available in each region.
- This bill recognizes that continued support of the DOEA is important to the Medicaid program and will still play a role in assessing or assisting recipients. CARES staff at the DOEA will continue to assist with initial assessments of an enrollee's level of care and will be responsible for assisting clients to interact with plans.
- Aging Resource Centers (ARCs) will provide enrollment and coverage information about the Medicaid managed care long-term care program under CS/HB 7107.
- ARCs can assist elders with information about services and long-term care managed care; help recipients resolve complaints; and make initial assessments about elders' needs.

Nursing Home Certificate of Need

- The bill extends the moratorium on certificates of need (CONs) for additional nursing home beds until the Medicaid managed care program under CS/HB 7107, is implemented statewide or October 1, 2016, whichever is earlier.
- Effective July 1, 2012, the bill prohibits the AHCA from imposing a sanction on a nursing home for failure to meet the Medicaid patient-day utilization conditions for that nursing home.

AHCA Reorganization

- The AHCA is directed to develop a reorganization plan for realignment of administrative resources of the Medicaid program to respond to changes in functional responsibilities and priorities necessary for implementation of CS/HB 7107.
- The reorganization plan must assess the AHCA's current capabilities, identify shifts in staffing and other resources necessary to strengthen procurement and contract monitoring functions, and establish an implementation timeline.
- The plan must be submitted to the Governor, the Speaker of the House of Representatives, and the President of the Senate by August 1, 2011.

If approved by the Governor, these provisions take effect July 1, 2011.
Vote: Senate 26-12; House 80-39