

TALKING POINTS FOR CS/ HB 7109

HB 7109 makes date specific, conforming changes to current law (e.g., setting an expiration date for certain sections of existing law) and authorizes some immediate changes to the Medicaid program.

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, they 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

- Expands the disqualification of Medicaid benefits from 5 to 10 years for a person found to have committed Medicaid fraud .
- Directs AHCA to request a federal approval to develop a system to require parents with 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 children.
- Directs AHCA to request federal approval to require Medicaid recipients to pay \$100 co-payments for nonemergency services provided in a hospital.
- Includes medically necessary dental, vision, hearing, and podiatric as required services in nursing homes.
- Provides that Medicaid shall not pay for psychotropic medications for a child unless specifically authorized by the parent or guardian.

Managed Care

- The bill will implement policies that build upon successes in the current reform areas and get us ready for statewide managed care.

- AHCA is required to develop uniform accounting and reporting requirements for the plans. The plans must begin reporting their medical and non-medical costs to the agency. This information must be made public. This valuable information will ensure that plans are providing adequately managed, patient-centered care.
- While many plans have begun to report encounter data to AHCA statewide, we establish a requirement for this data to ensure compliance by all plans.
- Plans will be given advance notice and an opportunity to comment on any potential rate adjustments by AHCA, as AHCA will do a simulated rate setting prior to making rate adjustments, the results of which must be posted on AHCA's website for 45 days.
- We expand statewide the current option for Medicaid recipients in reform counties who may use their Medicaid premium to purchase employer-sponsored insurance; however, we build upon this option (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. This broadens the choice options for recipients while still bridging public and private coverage.
- We protect specialized or unique, time-limited and on-going care patients may be receiving at the time they enroll in Medicaid from providers who do not contract with Medicaid managed care plans by authorizing AHCA on a case-by-case basis to exempt these recipients from managed care.
- AHCA is required to contract with prepaid dental plans until Medicaid managed care is fully implemented in all regions.

Dual Eligibles

- The agency is authorized to develop payment methodologies to cover the state's share of cost for individuals eligible for both Medicare and Medicaid.
- Additional requirements are imposed on Medicare crossover providers to assist AHCA in fraud prevention.

Hospital Rates

- AHCA is directed to implement a methodology for establishing base reimbursement rates for each hospital based on allowable costs. The rates will be set only once annually and the reconciliation period is limited. This process will provide budgetary certainty and administrative simplification.
- 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.
- AHCA must submit the Medicaid DGR plan to the Governor and legislature by January 1, 2013.

Provider Service Networks

- We apply some of the same payment requirements applicable to PSNs in reform counties to all PSNs statewide in order to prepare them for expansion of managed care statewide
- PSNs may still be fee-for-service for a period of time, but we establish specific requirements for shared savings and define guidelines for a reconciliation process that determines shared savings.

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 shall expire when the managed care program is fully implemented.

Nursing Home Regulatory Relief

- To enable nursing homes to be able to provide comprehensive services pursuant to the long-term care managed care program, it is essential that we ensure some regulatory relief to nursing facilities.
- Nursing homes will have CON relief in two ways:
 - Current facility obligations related to utilization by Medicaid recipients are suspended, and

- Current CON moratorium on nursing home beds is extended until Medicaid managed care – medical assistance, long-term, and long-term for persons with developmental disabilities – is implemented statewide or October 1, 2015, whichever is earlier.

Medically Needy Program

- The medically needy are a unique population that has not previously been served by managed care in Florida.
- AHCA is directed immediately to contract with a PSN to coordinate and manage the care of the Medically Needy. They will be continuously enrolled for a period of six months. The enrollee's shall 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 premium. The
- The contact with the PSN will expire when the Managed Medical Assistance Program is effective statewide.
- Additionally, AHCA is directed to develop a plan for transitioning medically needy recipients into the Managed Medical Assistance Program. AHCA is to immediately seek any federal authorization needed for the implementation.

Tort Reform

- To encourage greater participation by doctors in the Medicaid Program, A cap is placed on non-economic damages that can be paid to Medicaid recipients.
- The cap is \$300,000 for an individual, but no single provider will pay more than \$200,000.

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. However, they 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 DOEA is important to the Medicaid program and will still play a role in assessing or assisting recipients.
 - CARES staff at 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.
- ARCs will provide enrollment and coverage information about the Medicaid managed care long-term care program and help recipients resolve complaints.
- ARCs will continue to assist elders with information about other types of services available in the community.