CARLTON FIELDS
ATTORNEYS AT LAW

Capitol Report

Government Affairs and Lobbying

May 16, 2011

To keep you informed of legislative changes resulting from the 2011 Florida Regular Legislative Session, Carlton Fields' **Government Law and Consulting** practice group is pleased to provide you with our latest legislative summary concerning Medicaid reform enacted by the 2011 Florida Legislature. As of this writing, the bills discussed below are awaiting review by the Governor and are subject to his veto authority. The reader is encouraged to check the ultimate status of the bill by visiting the Legislature's web site (*www.leg.state.fl.us)*. Please select the "Enrolled" (ER) version of the bill.

Committee Substitute for House Bills 7107 and 7109
(CS/HB 7107 and 7109)
Medicaid Reform

In the final days of the 2011 Legislative Session, the House and Senate agreed to massive reform of the state's Medicaid program contained in CS/HBs 7107 and 7109.

With unemployment rates at an all time high, more and more Floridians find themselves seeking health coverage through the state/federal program. Almost 3 million persons are covered by Florida's $22 billion dollar Medicaid program. While over half of those persons are currently enrolled in "managed care organizations" including health maintenance organizations ("HMOs"), provider service networks ("PSNs"), and specialty care plans; under the sweeping Reform proposal almost all Medicaid eligible persons will be required to join managed care plans – provided the state's overall Reform Plan is approved by the Centers for Medicare and Medicaid Services ("CMS"). CMS has already shared some insights regarding what they are looking for: quality, stability, transparency & accountability, and evaluation. CMS expressly stated that each plan maintain a specific "medical loss ratio;" but, instead the Florida Legislature adopted an "achieved savings rebate" model, which is essentially HMOs' profit sharing with the state. This deviation may jeopardize approval from CMS. Another CMS hurdle will be the continued use of over $800 million in intergovernmental transfer dollars as the state share of the Medicaid program.

Provided CMS approves the Plan, additional highlights of Medicaid Reform Proposal include:

- Roll out of reform for long term care is set to begin July 2012 with implementation in October 2013.

- Bids for the base Medicaid program (children and families) will go out January 2013 with full implementation anticipated October 2014.

- Bidding will be done statewide by Region – there are 11 regions based on the existing Agency for Health Care Administration health planning areas.

- Bidders are being asked to show savings of at least 5% during the first year of operation.

- Each plan is targeted to manage 45,000 lives, but plans already in operate get first dibs on current enrollees.

- Provider Service Networks will be able to be paid on fee-for-service basis instead of risk-adjusted capitated rates for the first 2 years of operation.

- Intergovernmental transfer dollars will flow through a single entity called the "Access to Care Partnership," which will in turn pay the intended providers.

- Hospital rate rebasing will be set on a pre-determined, statutorily prescribed basis using 3 tiers of hospitals.

- Supplemental payments to faculty physicians will be made through the "Florida Medical Schools Quality Network."

- Federally qualified health centers, teaching hospitals, and trauma centers may be considered "essential providers," with which all plans in their region must contract; absent a contract, plans will pay essential providers at the rate in effect at the time the plan contracts with the agency.

- Faculty practice plans, Regional Perinatal Intensive Care Centers, and children's hospitals are considered "statewide essential providers" and must be included in all plans; absent a contract, various reimbursement rates apply.

- Caps are placed on reimbursement to hospitals at 120% of the Medicaid rate.

- Hospital rates, which are currently set each July 1 and January 1, will be set by September 30 of each year.

- Payments to non-contracted providers for emergency care and treatment are set at "the rate the agency would have paid on the most recent October 1st."

- Caps are placed on the award of non-economic damages paid to Medicaid recipients. The limit is $300,000 per claimant and limits liability to a practitioner to no more than $200,000, unless the claimant pleads and proves the provider acted in a wrongful manner.

- Medicaid recipients qualifying as “Medically Needy” will be required to pay their share of the costs of the monthly capitated rate.

- A $100 fee is imposed on Medicaid enrollees for the non-emergent use of emergency rooms.

For more information, please contact:

Jan Gorrie, Shareholder
813.229.4395 direct
jgorrie@carltonfields.com
View Bio
V-Card

CARLTON FIELDS
ATTORNEYS AT LAW

www.carltonfields.com

Atlanta | Miami | Orlando | St. Petersburg | Tallahassee | Tampa | West Palm Beach