The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Policy Committee

BILL:	SB 1566
INTRODUCER:	Senator Lynn
SUBJECT:	Medicaid Managed Care Plans
DATE:	March 15, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HP	**Favorable**
2.			HR	
3.			BI	
4.			HA	
5.				
6.				

I. Summary:

This bill requires health insurers, prepaid limited health service organizations, and health maintenance organizations that provide comprehensive behavioral health care services in the Medicaid program to continue to offer medically necessary services authorized by the entity previously covering a Medicaid recipient while prior authorization is being processed under a new plan. The bill requires these entities to pay "clean claims," or those that have been presented with no defects or improprieties, within 10 business days of receipt. The bill requires these entities to develop and maintain informal grievance systems that address provider payment and contract problems, and requires the Agency for Health Care Administration (AHCA) to establish a formal grievance system to address those issues not resolved by the informal grievance system.

This bill amends s. 409.912, F.S.

II. Present Situation:

Florida Medicaid Program

Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The AHCA is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[1] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[2] Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, Florida Statutes.

For Fiscal Year 2008-09, the Florida Medicaid Program is projected to cover 2.25 million people[3] at an estimated cost of $15.8 billion.[4]

Medicaid Managed Care Programs

The state of Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[5] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is broken into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program. This bill does not affect these individuals, so they are excluded for this analysis.

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and referral and authorization for specialty services and hospital care. The primary care providers are expected to monitor appropriateness of health care provided to their patients. MediPass providers receive a $3 monthly case management fee for each of their enrolled patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered.

The second major category of provider in the Medicaid managed care program is the managed care plan. Section 409.9122, F.S., defines managed care plans as health maintenance

[1] These mandatory services are codified in s. 409.905, F.S.
[2] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.
[3] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on March 15, 2008).
[4] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on March 15, 2008).
[5] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

organizations (HMOs), exclusive provider organizations (EPOs), provider service networks (PSNs), minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs. These plans tend to be reimbursed through a capitated payment where the plan receives a set amount per member per month and is responsible for providing all necessary Medicaid services within that capitation rate.

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., the AHCA is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not make a choice within 30 days of eligibility. There are 23 counties with MediPass as the only managed care choice, ten counties have one managed care plan and MediPass, and 29 counties have at least two managed care plans in addition to MediPass.

As of January 2008, there were 2,107,427 individuals enrolled in the Florida Medicaid program. Of these Medicaid recipients, 195,230 are enrolled in the Medicaid reform pilot and 1,912,197 are enrolled in the non-reform component of the program. Of those individuals not in the reform counties, 1,265,562 are eligible for mandatory managed care. Of the individuals eligible for mandatory managed care enrollment, they are enrolled in the following types of plans in these numbers: 362,505 are enrolled in MediPass; 586,361 are enrolled in HMOs; 117,523 are enrolled in minority physician networks; 24,274 are enrolled in the Children's Medical Services Network; 7,521 are enrolled in PSNs; and 6,258 are enrolled in pediatric emergency room diversion plans.

Medicaid Prepaid Behavioral Health Plans

In March 1996, the AHCA implemented a Prepaid Mental Health Plan (PMHP) demonstration, under the authority of the 1915(b) Medicaid managed care waiver. The program was piloted for many years in two areas of the state before being expanded statewide in 2004, and is codified in s. 409.912(4), F.S.

A prepaid behavioral health plan is a managed care organization that contracts with the AHCA to provide comprehensive mental health services to its members though a capitated payment system. The AHCA pays a per member, per month (PMPM) fee to the plan based on the age and eligibility category of each member. Services provided by these plans must include:

- Inpatient Psychiatric Hospital Services,
  - 45 days for adult recipients
  - 365 days for children
- Outpatient Psychiatric Hospital Services,
- Psychiatric Physician Services,
- Community Mental Health Services, and
- Mental Health Targeted Case Management.

Medicaid recipients who elect to enroll in MediPass for the provision of their physical health care services are assigned to a prepaid behavioral health plan for the provision of their mental health services, unless they are ineligible. Ineligible persons include:

- Recipients who have both Medicaid and Medicare coverage (dual eligibles),
- Persons living in an institutional setting, such as a nursing home, state mental health treatment facility, or prison,
- Medicaid-eligible recipients receiving services through hospice,
- Recipients in the Medically Needy Program,
- Newly enrolled recipients who have not yet chosen a health plan,
- SOBRA-eligible pregnant women and presumptively eligible pregnant women,
- Individuals with private major medical coverage,
- Members of a Medicaid HMO if the HMO has chosen to provide behavioral health services,
- Recipients receiving FACT services, and
- Children enrolled in the HomeSafeNet database, unless they are enrolled in a Medicaid reform managed care plan in Broward County.

Because of their unique situation, children in the HomeSafeNet database are excluded from participating in the prepaid behavioral health plan. A separate prepaid plan was developed for these children to provide services (including behavioral health services) operated by community based lead agencies as of July 1, 2005, that are contracted through the Department of Children and Family Services.

There are times when Medicaid recipients may transfer between managed care plans, or move from a prepaid behavioral health plan to a Medicaid HMO to receive mental and behavioral health services. Contracts with Medicaid managed care plans for comprehensive behavioral health care services currently provide enrollees the opportunity to continue to receive medically necessary prior authorized services from their current provider until services are prior authorized by the new managed care plan. This lack of service interruption ensures continuity of services and is consistent with "best practice" guidelines. However, this arrangement is only provided through the contract arrangement and is not codified in state statute.

Managed Care Prompt Payment of Claims

Both federal and state law have specific requirements for the payment of claims submitted through the Medicaid program. Federal regulations in 42 CFR 447.45(d)(2) require state Medicaid agencies to pay 90 percent of all clean claims within 30 days of receipt, and pay 99 percent of clean claims within 90 days of receipt. Other federal regulations [42 CFR 447.46(c)] require state Medicaid agency contracts with managed care organizations to hold those organizations to the requirements of 42 CFR 447.45(d) with regard to the timely payment of claims.

Section 641.3155(3), F.S., currently requires clean claims submitted electronically to an HMO licensed under ch. 641, F.S., to be paid within 20 days of receipt. Section 641.3155(4), F.S., requires that receipt of non-electronic clean claims must be acknowledged by the HMO within 15 days and paid within 40 days of receipt. The provisions are often referred to as "prompt payment" provisions and are meant to ensure that a provider under contract with an HMO does not develop cash flow problems due to outstanding claims payments. These provisions apply to Medicaid HMOs by nature of the licensure.

Contracts between the AHCA and Medicaid HMOs hold those organizations to the prompt payment standards outlined in ch. 641, F.S., and are in compliance with standards outlined in 42 CFR 447.46(c). Prepaid behavioral health plans contracting with the AHCA to provide services to Medicaid recipients are held to the standards outlined in 42 CFR 447.4 (c).

Medicaid Managed Care Provider Grievance Procedures

State law does not currently address grievance procedures related to Medicaid managed care plans. The grievance systems developed and maintained by Medicaid managed care plans are contractual in nature. Although the established grievance systems vary by managed care plans, all inform the enrollees of their right to file a fair hearing request at any point in the grievance process. The established grievance systems are not meant to be a tool for providers to address payment and contract problems. Provider contracts include language to address payment and contract problems with the managed care plans. Each managed care organization has a contractually established provider complaint system to address provider concerns regarding payment and contract problems. If providers are unable to satisfactorily address their concerns through the complaint system, they are able to address them through an informal appeals process facilitated by the AHCA.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.912, F.S., requiring entities licensed under ch. 624, F.S. (health insurers), ch. 636, F.S. (prepaid limited health service organizations), or ch. 641, F.S. (HMOs), which provide Medicaid comprehensive behavioral health care services to:

- Continue to offer medically necessary services authorized by an entity previously covering a Medicaid recipient while prior authorization is being processed under a new plan;
- Pay, within 10 business days after receipt, electronic clean claims containing sufficient information for processing; and
- Develop and maintain an informal grievance system to address payment and contract problems with physicians licensed under ch. 458, F.S., or ch. 459, F.S., psychologists licensed under ch. 491, F.S., psychotherapists as defined in ch. 491, F.S., or a facility operating under ch. 393, F.S. (facilities for the developmentally disabled), ch. 394, F.S.(facilities for the mentally ill), or ch. 397, F.S. (facilities for clients receiving substance abuse services).

In addition, the bill requires the AHCA to establish a formal appeals system to address provider issues not resolved through the plans' informal grievance/provider dispute resolution system.

Section 2. Provides that the bill takes effect July 1, 2008.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The AHCA states that the proposed changes pertaining to continuity of care would have no fiscal impact on the agency because of the capitation method of payment made to Medicaid managed care organizations.

There is currently no formal system to address payment problems for Medicaid managed care entities and the proposed legislation does not specify any requirements of the process. The fiscal impact of this requirement as stated in the bill is indeterminate at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill would decrease the length of time allowed for health insurers, prepaid limited health service organizations, and health maintenance organizations that provide Medicaid comprehensive behavioral health care services to process clean claims for payment. Prompt payment requirements are already codified in s. 641.3155, F.S., and in federal law. The proposed language would establish a separate statutory payment requirement specifically for Medicaid comprehensive behavioral health plans, a subset of managed care plans. The existence of three separate statutory frameworks for prompt payment of Medicaid provider claims (federal law fee-for-service requirements, Medicaid health maintenance organization under existing statutes, and the Medicaid comprehensive behavioral health organization created under this law) is likely to create additional administrative workload for the plans and providers, as well as the potential for confusion when dealing with varying requirements for different programs within the Florida Medicaid Program.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.