By the Committee on Health Regulation; and Senator Storms

588-04069A-09 20092422c1

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 409.912,
3 F.S.; requiring that funds repaid to the Agency for
4 Health Care Administration by managed care plans that
5 spend less than a certain percentage of the capitation
6 rate for behavioral health services be deposited into
7 the Medical Care Trust Fund; providing that such
8 repayments be allocated to community behavioral health
9 providers and used for Medicaid behavioral and case
10 management services; providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Paragraph (b) of subsection (4) of section
15 409.912, Florida Statutes, is amended to read:
16 409.912 Cost-effective purchasing of health care.—The
17 agency shall purchase goods and services for Medicaid recipients
18 in the most cost-effective manner consistent with the delivery
19 of quality medical care. To ensure that medical services are
20 effectively utilized, the agency may, in any case, require a
21 confirmation or second physician's opinion of the correct
22 diagnosis for purposes of authorizing future services under the
23 Medicaid program. This section does not restrict access to
24 emergency services or poststabilization care services as defined
25 in 42 C.F.R. part 438.114. Such confirmation or second opinion
26 shall be rendered in a manner approved by the agency. The agency
27 shall maximize the use of prepaid per capita and prepaid
28 aggregate fixed-sum basis services when appropriate and other
29 alternative service delivery and reimbursement methodologies,

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30 including competitive bidding pursuant to s. 287.057, designed
31 to facilitate the cost-effective purchase of a case-managed
32 continuum of care. The agency shall also require providers to
33 minimize the exposure of recipients to the need for acute
34 inpatient, custodial, and other institutional care and the
35 inappropriate or unnecessary use of high-cost services. The
36 agency shall contract with a vendor to monitor and evaluate the
37 clinical practice patterns of providers in order to identify
38 trends that are outside the normal practice patterns of a
39 provider's professional peers or the national guidelines of a
40 provider's professional association. The vendor must be able to
41 provide information and counseling to a provider whose practice
42 patterns are outside the norms, in consultation with the agency,
43 to improve patient care and reduce inappropriate utilization.
44 The agency may mandate prior authorization, drug therapy
45 management, or disease management participation for certain
46 populations of Medicaid beneficiaries, certain drug classes, or
47 particular drugs to prevent fraud, abuse, overuse, and possible
48 dangerous drug interactions. The Pharmaceutical and Therapeutics
49 Committee shall make recommendations to the agency on drugs for
50 which prior authorization is required. The agency shall inform
51 the Pharmaceutical and Therapeutics Committee of its decisions
52 regarding drugs subject to prior authorization. The agency is
53 authorized to limit the entities it contracts with or enrolls as
54 Medicaid providers by developing a provider network through
55 provider credentialing. The agency may competitively bid single-
56 source-provider contracts if procurement of goods or services
57 results in demonstrated cost savings to the state without
58 limiting access to care. The agency may limit its network based

59 on the assessment of beneficiary access to care, provider
60 availability, provider quality standards, time and distance
61 standards for access to care, the cultural competence of the
62 provider network, demographic characteristics of Medicaid
63 beneficiaries, practice and provider-to-beneficiary standards,
64 appointment wait times, beneficiary use of services, provider
65 turnover, provider profiling, provider licensure history,
66 previous program integrity investigations and findings, peer
67 review, provider Medicaid policy and billing compliance records,
68 clinical and medical record audits, and other factors. Providers
69 shall not be entitled to enrollment in the Medicaid provider
70 network. The agency shall determine instances in which allowing
71 Medicaid beneficiaries to purchase durable medical equipment and
72 other goods is less expensive to the Medicaid program than long-
73 term rental of the equipment or goods. The agency may establish
74 rules to facilitate purchases in lieu of long-term rentals in
75 order to protect against fraud and abuse in the Medicaid program
76 as defined in s. 409.913. The agency may seek federal waivers
77 necessary to administer these policies.
78 (4) The agency may contract with:
79 (b) An entity that is providing comprehensive behavioral
80 health care services to ~~certain~~ Medicaid recipients through a
81 capitated, prepaid arrangement pursuant to the federal waiver
82 authorized in ~~provided for by~~ s. 409.905(5). Such an entity must
83 be licensed under chapter 624, chapter 636, or chapter 641 and
84 must possess the clinical systems and operational competence to
85 manage risk and provide comprehensive behavioral health care to
86 Medicaid recipients. As used in this paragraph, the term
87 “comprehensive behavioral health care services” means covered

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88 mental health and substance abuse treatment services that are
89 available to Medicaid recipients. The secretary of the
90 Department of Children and Family Services must ~~shall~~ approve
91 ~~provisions of~~ procurements related to children in the
92 department's care or custody before ~~prior to~~ enrolling such
93 children in a prepaid behavioral health plan. Any contract
94 awarded under this paragraph must be competitively procured. In
95 developing the behavioral health care prepaid plan procurement
96 document, the agency shall ensure that the ~~procurement~~ document
97 requires the contractor to develop and implement a plan to
98 ensure compliance with s. 394.4574 related to services provided
99 to residents of licensed assisted living facilities that hold a
100 limited mental health license. Except as provided in
101 subparagraph 8., and except in counties where the Medicaid
102 managed care pilot program is authorized pursuant to s.
103 409.91211, the agency shall seek federal approval to contract
104 with a single entity meeting these requirements to provide
105 comprehensive behavioral health care services to all Medicaid
106 recipients not enrolled in a Medicaid managed care plan
107 authorized under s. 409.91211 or a Medicaid health maintenance
108 organization in an AHCA area. In an AHCA area where the Medicaid
109 managed care pilot program is authorized pursuant to s.
110 409.91211 in one or more counties, the agency may procure a
111 contract with a single entity to serve the remaining counties as
112 an AHCA area or the remaining counties may be included with an
113 adjacent AHCA area and are ~~shall be~~ subject to this paragraph.
114 Each entity must offer a sufficient choice of providers in its
115 network to ensure recipient access to care and the opportunity
116 to select a provider with whom they are satisfied. The network

117 shall include all public mental health hospitals. ~~To ensure~~
118 ~~unimpaired access to behavioral health care services by Medicaid~~
119 ~~recipients, all contracts issued pursuant to this paragraph~~
120 ~~shall require 80 percent of the capitation paid to the managed~~
121 ~~care plan, including health maintenance organizations, to be~~
122 ~~expended for the provision of behavioral health care services.~~
123 ~~In the event the managed care plan expends less than 80 percent~~
124 ~~of the capitation paid pursuant to this paragraph for the~~
125 ~~provision of behavioral health care services, the difference~~
126 ~~shall be returned to the agency. The agency shall provide the~~
127 ~~managed care plan with a certification letter indicating the~~
128 ~~amount of capitation paid during each calendar year for the~~
129 ~~provision of behavioral health care services pursuant to this~~
130 ~~section.~~ The agency may reimburse for substance abuse treatment
131 services on a fee-for-service basis until the agency finds that
132 adequate funds are available for capitated, prepaid
133 arrangements.
134 1. By January 1, 2001, the agency shall modify the
135 contracts with the entities providing comprehensive inpatient
136 and outpatient mental health care services to Medicaid
137 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
138 Counties, to include substance abuse treatment services.
139 2. By July 1, 2003, the agency and the department ~~of~~
140 ~~Children and Family Services~~ shall execute a written agreement
141 that requires collaboration and joint development of all policy,
142 budgets, procurement documents, contracts, and monitoring plans
143 that have an impact on the state and Medicaid community mental
144 health and targeted case management programs.
145 3. Except as provided in subparagraph 8., by July 1, 2006,

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146 the agency and the department ~~of Children and Family Services~~
147 shall contract with managed care entities in each AHCA area
148 except area 6 or arrange to provide comprehensive inpatient and
149 outpatient mental health and substance abuse services through
150 capitated prepaid arrangements to all Medicaid recipients who
151 are eligible to participate in such plans under federal law and
152 regulation. In AHCA areas where eligible individuals number less
153 than 150,000, the agency shall contract with a single managed
154 care plan to provide comprehensive behavioral health services to
155 all recipients who are not enrolled in a Medicaid health
156 maintenance organization or a Medicaid capitated managed care
157 plan authorized under s. 409.91211. The agency may contract with
158 more than one comprehensive behavioral health provider to
159 provide care to recipients who are not enrolled in a Medicaid
160 capitated managed care plan authorized under s. 409.91211 or a
161 Medicaid health maintenance organization in AHCA areas where the
162 eligible population exceeds 150,000. In an AHCA area where the
163 Medicaid managed care pilot program is authorized pursuant to s.
164 409.91211 in one or more counties, the agency may procure a
165 contract with a single entity to serve the remaining counties as
166 an AHCA area or the remaining counties may be included with an
167 adjacent AHCA area and are ~~shall be~~ subject to this paragraph.
168 Contracts for comprehensive behavioral health providers awarded
169 pursuant to this section must ~~shall~~ be competitively procured.
170 Both for-profit and not-for-profit corporations are ~~shall be~~
171 eligible to compete. Managed care plans contracting with the
172 agency under subsection (3) shall provide and receive payment
173 for the same comprehensive behavioral health benefits as
174 provided in AHCA rules, including handbooks incorporated by

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175 reference. In AHCA area 11, the agency shall contract with at
176 least two comprehensive behavioral health care providers to
177 provide behavioral health care to recipients in that area who
178 are enrolled in, or assigned to, the MediPass program. One of
179 the behavioral health care contracts must ~~shall~~ be with the
180 existing provider service network pilot project, as described in
181 paragraph (d), for the purpose of demonstrating the cost-
182 effectiveness of the provision of quality mental health services
183 through a public hospital-operated managed care model. Payment
184 shall be at an agreed-upon capitated rate to ensure cost
185 savings. Of the recipients in area 11 who are assigned to
186 MediPass under the provisions of s. 409.9122(2)(k), a minimum of
187 50,000 of those MediPass-enrolled recipients shall be assigned
188 to the existing provider service network in area 11 for their
189 behavioral care.
190 4. By October 1, 2003, the agency and the department shall
191 submit a plan to the Governor, the President of the Senate, and
192 the Speaker of the House of Representatives which provides for
193 the full implementation of capitated prepaid behavioral health
194 care in all areas of the state.
195 a. Implementation shall begin in 2003 in those AHCA areas
196 of the state where the agency is able to establish sufficient
197 capitation rates.
198 b. If the agency determines that the proposed capitation
199 rate in any area is insufficient to provide appropriate
200 services, the agency may adjust the ~~capitation~~ rate to ensure
201 that care is ~~will be~~ available. The agency and the department
202 may use existing general revenue to address any additional
203 required match but may not over-obligate existing funds on an

204 annualized basis.
205 c. Subject to any limitations provided for in the General
206 Appropriations Act, the agency, in compliance with appropriate
207 federal authorization, shall develop policies and procedures
208 that allow for certification of local and state funds.
209 5. Children residing in a statewide inpatient psychiatric
210 program, or in a Department of Juvenile Justice or a Department
211 of Children and Family Services residential program approved as
212 a Medicaid behavioral health overlay services provider <u>may</u> ~~shall~~
213 not be included in a behavioral health care prepaid health plan
214 or any other Medicaid managed care plan pursuant to this
215 paragraph.
216 6. In converting to a prepaid system of delivery, the
217 agency shall in its procurement document require an entity
218 providing only comprehensive behavioral health care services to
219 prevent the displacement of indigent care patients by enrollees
220 in the Medicaid prepaid health plan providing behavioral health
221 care services from facilities receiving state funding to provide
222 indigent behavioral health care, to facilities licensed under
223 chapter 395 which do not receive state funding for indigent
224 behavioral health care, or reimburse the unsubsidized facility
225 for the cost of behavioral health care provided to the displaced
226 indigent care patient.
227 7. Traditional community mental health providers under
228 contract with the department ~~of Children and Family Services~~
229 pursuant to part IV of chapter 394, child welfare providers
230 under contract with the department ~~of Children and Family~~
231 ~~Services~~ in areas 1 and 6, and inpatient mental health providers
232 licensed pursuant to chapter 395 must be offered an opportunity

233 to accept or decline a contract to participate in any provider
234 network for prepaid behavioral health services.
235 8. All Medicaid-eligible children, except children in area
236 1 and children in Highlands County, Hardee County, Polk County,
237 or Manatee County of area 6, who are open for child welfare
238 services in the HomeSafeNet system, shall receive their
239 behavioral health care services through a specialty prepaid plan
240 operated by community-based lead agencies ~~either~~ through a
241 single agency or formal agreements among several agencies. The
242 specialty prepaid plan must result in savings to the state
243 comparable to savings achieved in other Medicaid managed care
244 and prepaid programs. Such plan must provide mechanisms to
245 maximize state and local revenues. The specialty prepaid plan
246 shall be developed by the agency and the department ~~of Children~~
247 ~~and Family Services~~. The agency may ~~is authorized to~~ seek any
248 federal waivers to implement this initiative. Medicaid-eligible
249 children whose cases are open for child welfare services in the
250 HomeSafeNet system and who reside in AHCA area 10 are exempt
251 from the specialty prepaid plan upon the development of a
252 service delivery mechanism for children who reside in area 10 as
253 specified in s. 409.91211(3)(dd).
254 9. To ensure unimpaired access to behavioral health care
255 services by Medicaid recipients, all contracts issued pursuant
256 to this paragraph must require that 80 percent of the capitation
257 paid to the managed care plan, including health maintenance
258 organizations, be expended for the provision of behavioral
259 health care services. If the plan expends less than 80 percent,
260 the difference must be returned to the agency and deposited into
261 the Medical Care Trust Fund. The agency shall maintain a

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262 separate accounting of repayments deposited into the trust fund.
263 Repayments, minus federal matching funds that must be returned
264 to the Federal Government, shall be allocated to community
265 behavioral health providers enrolled in the networks of the
266 managed care organizations that made the repayments. Funds shall
267 be allocated in proportion to each community behavioral health
268 agency's earnings from the managed care organization making the
269 repayment. Providers shall use the funds for any Medicaid-
270 allowable type of community behavioral health and case
271 management service. Community agencies shall be reimbursed by
272 the agency on a fee-for-service basis for allowable services up
273 to their redistribution amount as determined by the agency.
274 Reinvestment amounts must be calculated on an annual basis,
275 within 60 days after health plans file their annual 80-percent
276 spending reports. The agency shall provide the managed care plan
277 with a certification letter indicating the amount of capitation
278 paid during each calendar year for the provision of behavioral
279 health care services pursuant to this section.
280 Section 2. This act shall take effect upon becoming a law.

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