# SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 1134

SPONSOR: Health, Aging and Long-Term Care Committee, Senator Kirkpatrick

SUBJECT: Managed Care; Mental Health

DATE: April 22, 1999 REVISED: _____ _____ _____ _____

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Liem | Wilson | HC | Favorable/CS |
| 2. | | | FP | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

## I. Summary:

Committee Substitute for Senate Bill 1134 authorizes the Agency for Health Care Administration (AHCA or agency) to expand areas of operation of a comprehensive behavioral health care services plan being provided to certain Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk counties to Escambia, Santa Rosa, Okaloosa, Walton, Baker, Nassau, Duval, Clay, St. Johns, and Dade counties. The bill requires that, in counties which have a Medicaid population which exceeds 300,000, the agency award 1 contract for every 100,000 recipients. The bill requires that the program be competitively procured and reimbursed through a capitated, prepaid arrangement, and sets standards for elements to be contained in the procurement.

The bill requires close consultation and coordination between the agency and the Departments of Children and Family Services (DCF) and Juvenile Justice (DJJ), and requires the agreement of the secretaries of those departments to certain portions of the procurement process prior to the enrollment of children in custody of those agencies in the comprehensive behavioral health care plan. The Department of Children and Family services is to be included in all aspects of contract oversight.

The bill exempts certain Medicaid recipients participating in the prepaid behavioral health care plan in certain counties. The bill requires the participation, and planning for participation, of a variety of traditional mental health, substance abuse, child caring providers, child caring and placing agencies, and hospitals in the prepaid provider network. The bill requires agency and departmental approval of certain protocols and requires that substance abuse treatment services be reimbursed on a fee-for-service basis until funds are available for capitated payment.

The bill requires that there be no displacement of indigent care patients from facilities receiving state funds for their care to hospitals which do not receive these funds without compensation of the facilities not receiving state funds.

The bill requires notification of the legislature of status and plans in expanding behavioral managed care projects to specified counties. The bill requires a local planning process for the further expansion of behavioral managed care projects, and the participation of contracted providers and hospitals.

The bill amends s. 409.912, F.S., 1998 Supplement.

## II. Present Situation:

Public mental health services are funded by both the Medicaid program and the Alcohol, Drug Abuse and Mental Health program of the Department of Children and Families. The Medicaid program reimburses the cost of covered mental health services for persons who meet financial eligibility criteria; DCF contracts for services not covered by Medicaid or services to individuals who are not Medicaid-eligible. In Fiscal Year 1997-98 the two agencies spent over $984 million on mental health and substance abuse services. Federal funds covered 39 percent of these costs. Medicaid funding for community-based mental health and substance abuse programs has grown from 24 percent of program appropriations in Fiscal Year 1992-93 to 28 percent in Fiscal Year 1997-1998.

The agency is directed in s. 409.912, F.S., to maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate, and other alternative service delivery and reimbursement methodologies, including competitive bidding, to facilitate the cost-effective purchase of a case-managed continuum of care. The section also authorizes the agency to contract with a variety of entities on a prepaid per capita or prepaid aggregate fixed-sum basis for the provision of goods and services to Medicaid recipients.

Section 409.912(3)(b), F.S., allows the agency to use a capitated, prepaid arrangement to deliver comprehensive inpatient and outpatient mental health care to certain Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk counties pursuant to a federal waiver provided for by s. 409.905(5). F.S. The provision specifies that the Medicaid mental health managed care demonstration project provider must become licensed under chapter 624, F.S., which provides the general indemnity insurance regulatory provisions of the Florida Insurance Code; chapter 636, F.S., which provides the regulatory structure for the regulation of prepaid limited health service organizations by the Department of Insurance; or chapter 641, F.S., which provides the regulatory structure for Health Maintenance Organizations.

The purpose of a prepaid mental health managed care model is to assist AHCA in predicting and containing Medicaid costs for mental health services, and to allow additional flexibility in using provider types and arrangements not allowed under the fee-for-service Medicaid system. A managed care model uses techniques such as clinical protocols, prior approval and utilization management to control cost, type and frequency of services.

The Medicaid mental health managed care demonstration project is currently operational in the Department of Children & Family Services Districts 6 & 14. In these districts, Medicaid mental health services for MediPass enrollees (i.e., Medicaid enrollees who are assigned a primary care physician case manager by Medicaid) are provided through a single prepaid mental health plan. When Medicaid recipients are enrolled in HMOs they receive the full range of mental health

services from the HMO they have chosen. The mental health plan receives a flat monthly payment per enrollee (the capitation rate) and is at risk to provide the full range of mental health care to their enrollees, excluding pharmaceuticals. This approach is often referred to as a carve-out design because mental health services are administered and financed separately from physical health services. Medicaid substance abuse services continue to be provided on a fee-for-service basis in these districts.

Some HMOs subcontract mental health services to providers at a flat monthly payment per enrolled individual and keep a portion of the fee to cover administrative cost. A concern with this arrangement is that service dollars for individuals in need of mental health services shrink each time there is a subcontract for services.

In the remainder of the state, all Medicaid mental health and substance abuse services are provided on a fee-for-services basis for both Medipass enrollees (without preauthorization by the primary care physician) and HMO enrollees. HMOs authorize and pay both medical and psychiatric inpatient admissions for their enrollees.

## III. Effect of Proposed Changes:

The bill amends s. 409.912, F.S., 1998 Supplement, to:

- Change “an entity providing comprehensive inpatient and outpatient mental health care services” to “a comprehensive behavioral health care services plan,” and expand counties in which the plan can operate to include Escambia, Santa Rosa, Okaloosa, Walton, Baker, Nassau, Duval, Clay, St. Johns, and Dade counties.

- Require one contract per 100,000 Medicaid recipients in counties with over 300,000 Medicaid recipients.

- Require the agency to set an allowable medical/loss ratio using industry standards adjusted based on the size of the plan.

- Require close coordination between AHCA and the Department of Children and Family services and the Department of Juvenile Justice in developing the procurement process regarding all matters which may affect services to clients, and makes enrollment of children in the care or custody of the state contingent on the approval of the secretaries of these departments of the provisions of the procurement process which relate to these children and their families, and the sections of the procurement which relate to the service transition while permanency is being achieved. DCF must be involved in all aspects of the oversight of contracts awarded.

- Exclude recipients participating in a provider service network that is in operation on October 1, 1999, from participating in the behavioral health prepaid plan established by the bill.

- Define “behavioral health care” to include mental health and substance abuse treatment.

- Prohibit children who reside in a residential program of the Department of Juvenile Justice, which is approved as a Medicaid behavioral health overlay services provider, from being included in a behavioral health care plan.

- In Baker, Nassau, Duval, Clay, St. Johns, and Dade counties the plan may not include children placed by a licensed residential group care facility operated by a Medicaid community mental health provider; children in the care or custody of the state who receive therapeutic or supportive foster care; services to children in emergency shelter; or children served under the community mental health program specializing in therapeutic foster care.

- In Baker, Nassau, Duval, Clay, St. Johns, and Dade counties, existing child caring and child placing agencies that are community mental health providers must be part of the provider network.

- Require prior approval by the agency and the appropriate department of protocols for services to children referred for follow up by child protection teams.

- Require that substance abuse treatment services be reimbursed fee-for-service until the agency determines that adequate funds are available for prepaid methods.

- Require that the agency ensure that contractors propose methods to integrate services and opportunities to become partners in the prepaid plan provider networks.

- Require that the plan ensure that indigent care patients are not displaced from hospitals which receive state funds to those which do not, unless unsubsidized facilities are reimbursed the cost of the care they provide. Traditional providers of inpatient care must be included in the prepaid behavioral health care plan panel of providers.

- Require that the agency notify the legislature of the status and plans to expand the behavioral managed care projects by March 15, 2000, with a description, in the instance that the 3 year time frame is not met, of the reasons and efforts which should be made, including alternatives to behavioral managed care. The plan must also address the status of services to children in care and custody of DCF and DJJ, as to how the services for these children will be integrated into the comprehensive behavioral health care program or alternative methods over the 3 year phase in.

- Requires a local planning process prior to an expansion of behavioral managed care projects, including input from a variety of providers currently under contract with DCF, DJJ or the agency, including licensed hospitals.

- Require that traditional community health centers under contract pursuant to chapter 394, F.S., be included in provider networks for prepaid behavioral health services.

The bill will take effect October 1, 1999.

## 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, Subsections 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. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Agency for Health Care Administration projects a fiscal impact for the bill of $175,792 the first year of implementation and $234,389 the second year. The fiscal impact of compensating non state supported hospitals for indigent care provided to indigent individuals displaced from facilities which receive state funds is unknown.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

The bill does not provide a definition of “comprehensive behavioral health care.”

The bill requires the plan to ensure certain conditions. It is unclear as to whether this the plan is the behavioral health care plan or a planning document.

The bill excludes certain Medicaid recipients in certain counties from participation in the project. This exclusion may require a specific federal waver.

The bill requires that some Medicaid providers participate in the prepaid provider network. Requiring a provider to enter into a contract with a managed care organization may be precluded under federal regulations.

The bill makes mention of a 3 year time frame but does not lay out this time frame.

## VIII. Amendments:

None.