A bill to be entitled

An act relating to self-directed care and mental health system improvements; amending s. 394.9084, F.S., relating to the Florida Self-Directed Care program; requiring the Department of Children and Family Services to expand access to the program, within existing resources; deleting provisions relating to development of a pilot project; revising provisions relating to implementation and administration of the program; providing for program applicants to be considered for enrollment regardless of level of functioning; providing for sources of funding; removing vocational rehabilitation and the Social Security Administration as subcomponents of the program; requiring eligible individuals to agree with program requirements and responsibilities; defining the term "independent financial agent"; requiring the independent financial agent, rather than the managing entity, to pay for certain services; removing obsolete provisions relating to obtaining federal waivers; providing for family-directed care; requiring an annual evaluation of the program; removing a provision authorizing the department to provide certain funding for the evaluation; deleting the expiration date of the program; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to contract with provider service networks specializing in psychiatric disabilities to provide Medicaid services; providing for assignment to psychiatric specialty provider service networks; amending s. 409.91211, F.S.; authorizing

the agency to seek and contract with provider service networks specializing in psychiatric disabilities to provide services in the Medicaid managed care pilot program; providing for plan assignment processes; authorizing the agency to consider diagnoses and disabilities in making plan assignments; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 394.9084, Florida Statutes, is amended to read:

394.9084 Florida Self-Directed Care program.--

(1) The Department of Children and Family Services, in cooperation with the Agency for Health Care Administration, shall make the Florida Self-Directed Care program model of service delivery available in every district of the department using existing resources. The Florida Self-Directed Care program is a participant-directed ~~may develop a client-directed~~ and choice-based program that provides ~~pilot project in district 4 and three other districts to provide~~ mental health treatment and support services for ~~to~~ adults with severe and persistent ~~who have a serious~~ mental illness. ~~The department may also develop and implement a client-directed and choice-based pilot project in one district to provide mental health treatment and support services for children with a serious emotional disturbance who live at home. If established, any staff who work with children must be screened under s. 435.04.~~ The department ~~projects~~ shall

implement a payment mechanism ~~model~~ in which each participant ~~client~~ controls the money that is available for that participant's ~~client's~~ mental health treatment and support services. The department shall establish interagency cooperative agreements and work with the agency as necessary~~, the division, and the Social Security Administration~~ to implement and administer the Florida Self-Directed Care program.

(2) To be eligible for enrollment in the Florida Self-Directed Care program, a person must be an adult with a severe and persistent mental illness. Florida Self-Directed Care program applicants with different levels of psychological, social, and occupational functioning may be considered for enrollment. Individuals eligible for enrollment must agree to Florida Self-Directed Care program requirements and responsibilities.

(3) The Florida Self-Directed Care program includes the following sources of funding ~~has four subcomponents~~:

(a) State-funded ~~Department~~ mental health services, which include community mental health outpatient, community support, and case management services funded through the department. This subcomponent excludes Florida Assertive Community Treatment (FACT) services for adults; residential services; and emergency stabilization services, including crisis stabilization units, short-term residential treatment, and inpatient services.

(b) State-funded and federally funded ~~Agency~~ mental health services, which include community mental health services and mental health targeted case management services reimbursed by Medicaid.

~~(c) Vocational rehabilitation, which includes funds available for an eligible participant as provided by the Rehabilitation Act of 1973, 29 U.S.C. chapter 16, as amended.~~

~~(d) Social Security Administration.~~

(4) The independent financial agent ~~managing entity~~ shall pay for the ~~cost-efficient community-based~~ services the participant selects to meet his or her mental health care ~~and vocational rehabilitation~~ needs and goals as identified on his or her recovery plan. For purposes of this section, the term "independent financial agent" means a third-party administrator who is an individual, an entity, or a program that does not provide mental health services. The fees authorized to be paid to the independent financial agent shall be paid from existing program funds.

(5)(a) The department and the agency shall take all necessary action to ensure state compliance with federal regulations. ~~The agency, in collaboration with the department, shall seek federal Medicaid waivers, and the department shall expeditiously seek any available Supplemental Security Administration waivers under s. 1110(b) of the federal Social Security Act; and the division, in collaboration with the department, shall seek federal approval to participate in the Florida Self Directed Care program. No later than June 30, 2005, the department, agency, and division shall amend and update their strategic and state plans to reflect participation in the projects, including intent to seek federal approval to provide cashout options for eligible services for participants in the projects.~~

(b) The department may apply for and use any funds from private, state, and federal grants provided for self-directed care, family-directed care, voucher, and self-determination programs, including those providing substance abuse and mental health care.

(6) The department, the agency, and the division may transfer funds to the independent financial agent ~~managing entity~~.

(7) The department and~~,~~ the agency~~, and the division~~ shall have rulemaking authority pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this section. These rules shall be for the purpose of enhancing choice in and control over the purchased mental health ~~and vocational rehabilitative~~ services accessed by Florida Self-Directed Care program participants.

(8) The department and the agency shall ~~will~~ complete a memorandum of agreement to delineate management roles for operation of the Florida Self-Directed Care program.

(9) The department and~~,~~ the agency~~, and the division~~ shall each, on an ongoing basis, review and assess the implementation of the Florida Self-Directed Care program.

(a) The department shall ~~will~~ implement an annual evaluation of the program and shall ~~will~~ include recommendations for improvements in the program.

(b) At a minimum, the evaluation must compare between program participants and nonparticipants:

1. Re-hospitalization rates.

2. Levels of satisfaction.

3. Service utilization rates.

4. Residential stability.

5. Levels of community integration and interaction.

(c) The evaluation must assess ~~evaluate~~ adherence to the Centers for Medicare and Medicaid self-direction requirements, including:

1. Person-centered planning.

2. Individual budgets.

3. Availability of independently brokered services from recovery coaches and quality advocates.

4. Access to the program by all who are eligible to enroll.

5. Participant safety and program incident management planning.

6. An independently mediated grievance process.

(d) The evaluation must assess the economic self-sufficiency of the program participants, including the number of Individual Development Accounts.

(e) The evaluation must assess any adverse incidents resulting from the Florida Self-Directed Care program, including participant ~~consumer~~ grievances, conflicts of interest, and patterns of self-referral by licensed professions.

~~The department is authorized to spend up to $100,000 to pay for the evaluation. If the agency and the department obtain a federal waiver, the evaluation will be used to determine effectiveness.~~

~~(10) This section expires July 1, 2008.~~

Section 2. Paragraph (d) of subsection (4) of section

409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall 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 pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency,

to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing

Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(d) A provider service network, which may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency is authorized to contract with specialty provider service networks that exclusively enroll Medicaid recipients with psychiatric disabilities.

1. Except as provided in subparagraph 2., Medicaid recipients assigned to a provider service network shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract expiration date, regardless of any contractual provisions to the contrary. A provider service

network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

2. A Medicaid recipient with psychiatric disabilities who fails to select a managed care plan shall be assigned to a provider service network that exclusively enrolls Medicaid recipients with psychiatric disabilities, if such program is available in the geographic area where the recipient resides.

Section 3. Paragraph (ee) is added to subsection (3) of section 409.91211, Florida Statutes, and paragraph (a) of subsection (4) of that section is amended, to read:

409.91211 Medicaid managed care pilot program.--

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(ee) To seek applications for and contract with provider service networks specializing in care for recipients with

psychiatric disabilities. The agency shall develop and implement a definition of psychiatric disabilities for membership and assignment purposes and establish assignment processes for recipients with psychiatric disabilities who fail to choose a managed care plan.

(4)(a) A Medicaid recipient in the pilot area who is not currently enrolled in a capitated managed care plan upon implementation is not eligible for services as specified in ss. 409.905 and 409.906, for the amount of time that the recipient does not enroll in a capitated managed care network. If a Medicaid recipient has not enrolled in a capitated managed care plan within 30 days after eligibility, the agency shall assign the Medicaid recipient to a capitated managed care plan based on the assessed needs of the recipient as determined by the agency and the recipient shall be exempt from s. 409.9122. When making assignments, the agency shall take into account the following criteria:

1. A capitated managed care network has sufficient network capacity to meet the needs of members.

2. The capitated managed care network has previously enrolled the recipient as a member, or one of the capitated managed care network's primary care providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular capitated managed care network as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The capitated managed care network's primary care

providers are geographically accessible to the recipient's residence.

5. The existence of any known diagnoses or disabilities, including psychiatric disabilities.

Section 4. This act shall take effect July 1, 2007.