By Senator Lynn

7-03054A-08 20081566__

1 A bill to be entitled
2 An act relating to Medicaid managed care plans; amending
3 s. 409.912, F.S.; requiring an entity that contracts with
4 the Agency for Health Care Administration to provide
5 certain health care services to continue to offer
6 previously authorized services while prior authorization
7 is processed, pay certain claims, and develop and maintain
8 an informal grievance system; defining the term "clean
9 claim"; requiring the Agency for Health Care
10 Administration to establish a formal grievance process;
11 providing an effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Paragraph (b) of subsection (4) of section
16 409.912, Florida Statutes, is amended to read:
17 409.912 Cost-effective purchasing of health care.--The
18 agency shall purchase goods and services for Medicaid recipients
19 in the most cost-effective manner consistent with the delivery of
20 quality medical care. To ensure that medical services are
21 effectively utilized, the agency may, in any case, require a
22 confirmation or second physician's opinion of the correct
23 diagnosis for purposes of authorizing future services under the
24 Medicaid program. This section does not restrict access to
25 emergency services or poststabilization care services as defined
26 in 42 C.F.R. part 438.114. Such confirmation or second opinion
27 shall be rendered in a manner approved by the agency. The agency
28 shall maximize the use of prepaid per capita and prepaid
29 aggregate fixed-sum basis services when appropriate and other

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

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

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88 behavioral health care services" means covered mental health and
89 substance abuse treatment services that are available to Medicaid
90 recipients. The secretary of the Department of Children and
91 Family Services shall approve provisions of procurements related
92 to children in the department's care or custody prior to
93 enrolling such children in a prepaid behavioral health plan. Any
94 contract awarded under this paragraph must be competitively
95 procured. In developing the behavioral health care prepaid plan
96 procurement document, the agency shall ensure that the
97 procurement document requires the contractor to develop and
98 implement a plan to ensure compliance with s. 394.4574 related to
99 services provided to residents of licensed assisted living
100 facilities that hold a limited mental health license. Except as
101 provided in subparagraph 8., and except in counties where the
102 Medicaid 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. 409.91211
110 in one or more counties, the agency may procure a contract with a
111 single entity to serve the remaining counties as an AHCA area or
112 the remaining counties may be included with an adjacent AHCA area
113 and shall be subject to this paragraph. Each entity must offer
114 sufficient choice of providers in its network to ensure recipient
115 access to care and the opportunity to select a provider with whom
116 they are satisfied. The network shall include all public mental

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

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146 shall contract with managed care entities in each AHCA area
147 except area 6 or arrange to provide comprehensive inpatient and
148 outpatient mental health and substance abuse services through
149 capitated prepaid arrangements to all Medicaid recipients who are
150 eligible to participate in such plans under federal law and
151 regulation. In AHCA areas where eligible individuals number less
152 than 150,000, the agency shall contract with a single managed
153 care plan to provide comprehensive behavioral health services to
154 all recipients who are not enrolled in a Medicaid health
155 maintenance organization or a Medicaid capitated managed care
156 plan authorized under s. 409.91211. The agency may contract with
157 more than one comprehensive behavioral health provider to provide
158 care to recipients who are not enrolled in a Medicaid capitated
159 managed care plan authorized under s. 409.91211 or a Medicaid
160 health maintenance organization in AHCA areas where the eligible
161 population exceeds 150,000. In an AHCA area where the Medicaid
162 managed care pilot program is authorized pursuant to s. 409.91211
163 in one or more counties, the agency may procure a contract with a
164 single entity to serve the remaining counties as an AHCA area or
165 the remaining counties may be included with an adjacent AHCA area
166 and shall be subject to this paragraph. Contracts for
167 comprehensive behavioral health providers awarded pursuant to
168 this section shall be competitively procured. Both for-profit and
169 not-for-profit corporations shall be eligible to compete. Managed
170 care plans contracting with the agency under subsection (3) shall
171 provide and receive payment for the same comprehensive behavioral
172 health benefits as provided in AHCA rules, including handbooks
173 incorporated by reference. In AHCA area 11, the agency shall
174 contract with at least two comprehensive behavioral health care

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

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203 federal authorization, shall develop policies and procedures that
204 allow for certification of local and state funds.
205 5. Children residing in a statewide inpatient psychiatric
206 program, or in a Department of Juvenile Justice or a Department
207 of Children and Family Services residential program approved as a
208 Medicaid behavioral health overlay services provider shall not be
209 included in a behavioral health care prepaid health plan or any
210 other Medicaid managed care plan pursuant to this paragraph.
211 6. In converting to a prepaid system of delivery, the
212 agency shall in its procurement document require an entity
213 providing only comprehensive behavioral health care services to
214 prevent the displacement of indigent care patients by enrollees
215 in the Medicaid prepaid health plan providing behavioral health
216 care services from facilities receiving state funding to provide
217 indigent behavioral health care, to facilities licensed under
218 chapter 395 which do not receive state funding for indigent
219 behavioral health care, or reimburse the unsubsidized facility
220 for the cost of behavioral health care provided to the displaced
221 indigent care patient.
222 7. Traditional community mental health providers under
223 contract with the Department of Children and Family Services
224 pursuant to part IV of chapter 394, child welfare providers under
225 contract with the Department of Children and Family Services in
226 areas 1 and 6, and inpatient mental health providers licensed
227 pursuant to chapter 395 must be offered an opportunity to accept
228 or decline a contract to participate in any provider network for
229 prepaid behavioral health services.
230 8. For fiscal year 2004-2005, all Medicaid eligible
231 children, except children in areas 1 and 6, whose cases are open

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232 for child welfare services in the HomeSafeNet system, shall be
233 enrolled in MediPass or in Medicaid fee-for-service and all their
234 behavioral health care services including inpatient, outpatient
235 psychiatric, community mental health, and case management shall
236 be reimbursed on a fee-for-service basis. Beginning July 1, 2005,
237 such children, who are open for child welfare services in the
238 HomeSafeNet system, shall receive their behavioral health care
239 services through a specialty prepaid plan operated by community-
240 based lead agencies either through a single agency or formal
241 agreements among several agencies. The specialty prepaid plan
242 must result in savings to the state comparable to savings
243 achieved in other Medicaid managed care and prepaid programs.
244 Such plan must provide mechanisms to maximize state and local
245 revenues. The specialty prepaid plan shall be developed by the
246 agency and the Department of Children and Family Services. The
247 agency is authorized to seek any federal waivers to implement
248 this initiative. Medicaid-eligible children whose cases are open
249 for child welfare services in the HomeSafeNet system and who
250 reside in AHCA area 10 are exempt from the specialty prepaid plan
251 upon the development of a service delivery mechanism for children
252 who reside in area 10 as specified in s. 409.91211(3)(dd).
253 9. An entity providing comprehensive behavioral health care
254 services and licensed under chapter 624, chapter 636, or chapter
255 641 shall:
256 a. Continue services authorized by the previous entity as
257 medically necessary while prior authorization is being processed
258 under a new plan;
259 b. Pay, within 10 business days after receipt, electronic
260 clean claims containing sufficient information for processing.

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261 For purposes of this paragraph, the term "clean claim" means a
262 claim that does not have any defect or impropriety, including the
263 lack of any required substantiating documentation or particular
264 circumstance requiring special treatment that prevents timely
265 payment being made; and
266 c. Develop and maintain an informal grievance system that
267 addresses payment and contract problems with physicians licensed
268 under chapter 458 or chapter 459, psychologists licensed under
269 chapter 491, psychotherapists as defined in chapter 491, or a
270 facility operating under chapter 393, chapter 394, or chapter
271 397. The agency shall also establish a formal grievance system to
272 address those issues that were not resolved through the informal
273 grievance system.
274 Section 2. This act shall take effect July 1, 2008.