HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 691 Medicaid Recipients with Psychiatric Disabilities

SPONSOR(S): Zapata and others

TIED BILLS: **IDEN./SIM. BILLS:** SB 846

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	8 Y, 0 N	Quinn-Gato	Calamas
2) Healthcare Council		Quinn-Gato/ Massengale	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

HB 691 authorizes the Agency for Health Care Administration to contract with specialty provider service networks ("PSNs") that exclusively enroll Medicaid recipients with psychiatric disabilities. Further, the bill requires that, should the Medicaid recipient fail to select a managed care plan, the agency assign a Medicaid recipient with psychiatric disabilities to such specialty PSNs if a specialty PSN is available in the geographic area in which the recipient resides.

Similarly, in Medicaid reform pilot program areas, the bill requires the agency to contract with specialty PSNs specializing in psychiatric care, develop a definition of psychiatric disabilities in order to assign recipients to specialty PSNs, and develop a process for assigning recipients to such specialty PSNs when recipients fail to choose a managed care plan. Additionally, the bill requires the agency to take into account the existence of a recipient's known diagnoses or disabilities, including psychiatric disabilities, when assigning recipients who have not enrolled in a managed care plan within 30 days after eligibility is determined to managed care plans determined by the agency.

The fiscal impact on the Medicaid program is indeterminate, but the agency likely will require additional resources to implement (see Fiscal Comment section).

The bill is effective on July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Empower families-The bill benefits individuals and families by providing greater opportunity for specialized health care for individuals suffering from psychiatric disabilities.

Safeguard individual liberty-The bill increases health care options for Medicaid recipients with psychiatric disabilities.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid Managed Care

The Florida Medicaid Program pays for services in three ways: fee-for-service reimbursement to health care providers with direct contract relationships with the Medicaid program[1]; capitated fee payment to certain managed care organizations (Health Maintenance Organizations) which create provider networks by contract with health care providers and which bear full risk for the care of Medicaid recipients who enroll in the managed care organization; and fee-for-service reimbursement to certain managed care organizations (Provider Service Networks) which create provider networks by contract with health care providers and which must share any savings with the Medicaid program or pay Medicaid for lack of savings.

Medicaid uses a capitated payment model for Health Maintenance Organizations (HMOs), Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s. The HMOs are the provider type that account for the largest number of enrollees.

Rates for HMOs are set using basic risk adjustment factors (age, sex, geographic location and eligibility group), but are not established by assessing recipients' clinical risk. Within certain limits, Medicaid enrollees can choose to receive care in either a managed care or fee-for-service setting.[2] However, recipients who do not make a choice are automatically enrolled in either managed care plans or fee-for-service Medicaid disproportionately to reach a ratio of 65 percent and 35 percent, respectively.[3]

Medicaid uses fee-for-service reimbursement for Provider Service Networks (PSNs) such as minority physician networks. PSNs also receive a per-patient case management fee. Provider service networks are required by contract to demonstrate savings over historic fee-for-service care, and savings achieved above a set goal are shared with the PSN.[4] Historically, the contracts have provided that failure to achieve savings goals will result in reimbursement to Medicaid of a portion of the case management payments. While all minority physician networks have achieved savings to the Medicaid program, some networks have not met the savings goals set in their contracts.

[1] Also known as MediPass, the fee-for-service side of Medicaid involves primary case management by the agency.
[2] See s. 409.9122(2)(a), F.S.
[3] See s. 409.9122(2)(f),(k), F.S.
[4] Section 409.912(49), F.S.

Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized the Agency for Health Care Administration (AHCA) to seek and implement a federal waiver for a managed care pilot program.[5] AHCA received approval for the five-year pilot and began implementing reformed Medicaid in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007, pursuant to statutory direction. Current law sets a goal of statewide expansion by 2011.

The pilot program administers all health care services through managed care organizations, reimbursed using actuarially based, risk-adjusted, capitated rates. Reform allowed AHCA to open competition in the delivery of health care benefits by establishing a certification process, which permits a broad array of entities to become managed care plans upon meeting certain financial, programmatic, and administrative requirements.

In reform, risk-adjusted rates are achieved by considering the four factors used for non-reform HMOs (age, sex, geographic location and eligibility group), and an additional factor: clinical history. Recipients' clinical risk is scored based on a combination of historic drug claims and historic diagnosis information gleaned from encounter data submitted to AHCA by the health plans.[6] Without clinical risk adjustment, managed care organization payments might not reflect the level of risk they actually assume, and any one managed care plan may be overpaid or underpaid depending on the health status of the recipients who choose to enroll in that plan. This kind of risk adjustment creates disincentives for managed care plans to market to healthier recipients or to promote disenrollment by sicker individuals, often called "cherry picking." Rather, it creates incentives for managed care plans that have sicker patients to identify them as early as possible and work to manage their care to avoid experiencing high costs. Similarly, clinical risk adjustment creates opportunity for innovative managed care organizations to create plans that specialize in meeting the needs of high-risk patient groups.

Upon enrollment in Medicaid, recipients in reform counties have 30 days to voluntarily select a managed care plan. For those who do not make a choice, current law requires AHCA to assign the recipient to a plan "based on the assessed needs of the recipient as determined by the agency." In making such assignments, the agency must take into account several factors: the plan's network capacity; a prior relationship between the recipient and the plan or one of the plan's primary care providers; the recipient's preference for a particular network, as demonstrated by prior claims data; and geographic accessibility.[7]

Provider Service Networks

Provider Service Networks (PSNs) are organizations that are owned and operated by providers that deliver comprehensive health care to their enrolled population. By statute, providers in PSNs must have a controlling interest in the governing body of the PSN, and may make arrangements with physicians or other health care professionals, health institutions, or any combination thereof, to assume all or part of the financial risk on a prospective basis for the provision of basic health services by physicians, by other health professionals, or through the institutions.[8]

PSNs were introduced in the Florida Medicaid Program in 2002. In traditional Medicaid, PSNs use a fee-for-service payment system with payment limits and links between payments and quality of care through a series of performance indicators. In Medicaid reform counties, PSNs may be paid one of two

[5] Sections 409.91211 - 409.91213, F.S.

[6] The inclusion of clinical data in the risk adjustment is being phased in over three years. In addition, a statutory risk corridor preventing variance by more than 10 percent of the mean phases out in 2008. Ch. 409.91211(8), F.S.

[7] Section 409.91211(4)(a), F.S.

[8] Section 409.912(4)(d), F.S.

ways: PSNs may receive the capitated, risk-adjusted payment used by the HMOs; or, for the first three years and at the PSN's option, PSNs may be reimbursed on a fee-for-service basis which includes the savings reconciliation element required for non-reform areas.[9]

In non-Medicaid reform counties, PSNs provide comprehensive health care to enrollees; however, except for one PSN in Miami-Dade County, PSNs are not authorized to manage community behavioral health and targeted case management (see "Managed Behavioral Health Care in Florida" below).[10] Instead, when a PSN enrollee requires comprehensive behavioral health care[11], enrollees are referred by the PSN to a prepaid behavioral health plan for services.[12]

Under Medicaid reform, PSNs participate as managed care organizations in the pilot counties and compete with HMOs for recipient enrollment. PSNs may choose to be reimbursed on a fee-for-service basis or on a risk-adjusted capitated basis for the initial three years of the program, and then must convert to risk-adjusted capitated methodology used by HMOs in reform at the end of the third year of operation.[13]

In reform, AHCA is currently authorized to contract with specialty plans for certain populations,[14] and the fully risk-adjusted payment methodology of reformed Medicaid will establish the ability to adequately compensate and incentivize the development of these and other specialty PSNs. The 1115 Medicaid Reform Waiver approved by the Centers for Medicare and Medicaid Services mandates that the State review and approve specialty plans pursuant to criteria that includes the appropriateness of the target population and the existence of clinical programs or special expertise to serve that target population.[15]

Managed Behavioral Health Care in Florida

AHCA provides behavioral health services for Medicaid recipients statewide using capitated prepaid and managed care programs. Florida began testing managed care models for providing mental health care for Medicaid enrollees under a 1915(b) waiver, as a mental health carve-out demonstration project in 1996 in the Tampa Bay area. The purpose of the demonstration was to create a fully integrated mental health delivery system with financial and administrative mechanisms that support a shared clinical model.

Following the initial demonstration project, Florida has continued to expand managed care strategies to establish comprehensive mental health services for Medicaid beneficiaries. Initially these were reimbursed through a fee-for-service mechanism in which the state was at risk for mental health service utilization. For beneficiaries enrolled in the MediPass plan, both physical health and pharmacy benefits were paid for on a fee-for-service basis. For beneficiaries enrolled in a HMO, physical health and pharmacy benefits were paid for through a capitated arrangement.

State Plan services for mental health include:

- Inpatient psychiatric services.
- Outpatient hospital services for covered diagnosis.
- Community mental health services.
- Mental health targeted case management.

[9] Section 409.91211(3)(e), F.S.
[10] *See* s. 409.912(4)(b); Medicaid 2007-2008 Summary of Services, located at http://ahca.myflorida.com/Medicaid/pdffiles/SS_07_070701_SOS.pdf.
[11] "Comprehensive behavioral health care" refers to covered mental health and substance abuse treatment services. See s. 409.912(4)(b), F.S.
[12] See Agency for Health Care Administration 2008 Bill Analysis & Economic Impact Statement.
[13] Section 409.91211(3)(e), F.S.
[14] Section 409.91211(3)(bb) through (dd), F.S.
[15] Agency for Health Care Administration 2008 Bill Analysis and Economic Impact Statement.

- Psychiatrist physician services.

In 2005, with federal approval, Florida expanded managed care for mental health coverage under capitated Medicaid managed care plans throughout the state. Current law requires Medicaid to competitively procure a single prepaid behavioral health plan for each AHCA area, with a few exceptions.[16] AHCA has competitively procured a single prepaid behavioral health plan in each non-reform AHCA area. Those single plans currently exist in each AHCA area, with some exceptions and variances.[17]

Effect of Proposed Changes

Non-Reformed Medicaid

House Bill 691 authorizes AHCA to contract with specialty PSNs in non-reformed Medicaid that exclusively enroll Medicaid recipients with psychiatric disabilities. The bill modifies automatic assignment provisions for managed care recipients assigned to provider service networks, requiring AHCA to assign a Medicaid recipient with psychiatric disabilities who does not select a managed care plan within the specified time to such a specialty PSN should one be available in the geographic area in which the recipient resides.

It is unclear how the specialty PSNs will interact with the prepaid behavioral health plans currently under contract with AHCA. AHCA has interpreted the interaction between the bill and existing law to limit a specialty PSN to providing comprehensive health care, excluding behavioral healthcare, thereby requiring the specialty PSN to refer enrollees to a prepaid behavioral health plan for behavioral health services.[18]

Additionally, the term "psychiatric disability" for purposes of non-reform specialty PSNs is not defined in the bill.

Reformed Medicaid

The bill requires AHCA to seek applications for, and contract with, PSNs specializing in care for recipients with psychiatric disabilities in the reform pilot counties. Similar to provisions in current Medicaid reform law, the bill requires AHCA to establish assignment processes for such recipients who fail to choose a managed care plan. The bill does not expressly require such assignment, in apparent reliance on the provisions of current law requiring automatic assignment to plans based on the assessed needs of the recipient. The bill adds to the statutory criteria the agency must consider in making automatic assignments, requiring the agency to consider any known diagnoses or disabilities, including psychiatric disabilities. The bill requires AHCA develop a definition for the term "psychiatric disabilities" for purposes of reform specialty PSNs.

While current law requires the agency to assign recipients (who fail to make plan choices) to plans based on assessed needs, the bill refers to "known" diagnoses or disabilities. It is unclear whether "known" refers to Medicaid, or some other entity. If it is Medicaid's own knowledge about the recipient that is operative, this may negate any implication of a requirement for individualized clinical assessment in favor of an assessment based on (claims) information about the recipient already known to Medicaid. Under this interpretation, the use of the term "known" implies that new enrollees, with no Medicaid

[16] Section 409.912(4)(b), F.S.

[17] In AHCA Area 11, AHCA contracts with at least two comprehensive behavioral health care providers, one of which is a public hospital-operated PSN providing behavioral health services to a minimum of 50,000 MediPass recipients. Initially, in AHCA Area 6, the comprehensive behavioral health providers already under contract with AHCA were used and their contracts were later amended to include substance abuse treatment services. For children enrolled in Home SafeNet, comprehensive behavioral health services are provided through a specialty prepaid plan operated by a community based lead agency pursuant to s. 409.912(8), F.S.

[18] Agency for Health Care Administration 2008 Bill Analysis & Economic Impact Statement.

claims history, and current recipients without claims history indicating a psychiatric disability, would require no further assessment before assignment.

The effective date of the bill is July 1, 2008.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.912, F.S.; relating to cost-effective purchasing of health care.

Section 2. Amends s. 409.91211, F.S.; relating to Medicaid managed care pilot program.

Section 3. Providing an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate. See Fiscal Comments section.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   See fiscal comments below.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Some Medicaid recipients with behavioral health diagnoses are a high-risk. Specialty PSNs that develop in Medicaid reform counties as a result of this bill may need the targeted reimbursement that fully risk-adjusted rates without risk corridors can provide in order to meet the needs of their patients. Under current law, for most providers, risk corridors end in 2008, and full risk adjustment will be fully available in FY 2009-2010. However, specialty PSNs have the option to use full risk adjustment without risk corridors immediately.

D. FISCAL COMMENTS:

The bill would authorize AHCA to contract with a specialty PSN for recipients with psychiatric disabilities in non-reform areas, and require AHCA to contract with a specialty PSN for recipients with psychiatric disabilities in reform areas. AHCA has indicated that the fiscal impact cannot be determined at this time, and has raised the following issues:

- As no definition for psychiatric disability currently exists, it is unknown how many recipients may be eligible for enrollment in, and choose to enroll in or be assigned to, the specialty plan.

- For Medicaid reform areas, the next phase of expansion has not been determined by the Florida Legislature. Therefore, the number of recipients who may enroll in the specialty plan is not known.

- For non-reform areas, no proposals or applications for behavioral health specialty plans have been submitted to the agency, so it is unknown which counties would be covered by a specialty PSN and how many recipients might be enrolled. The number of children in the HomeSafeNet system who may meet the enrollment criteria for the specialty PSN will have to be assessed before the fiscal impact is known.

- The revisions to the assignment process may cause a delay in managed care enrollment processes such that additional fee-for-service expenditures may occur, which may be significant. The agency would need to develop a definition of psychiatric disabilities, an assessment tool and process in order to assess a recipient's psychiatric disability before assigning the recipient to a managed care plan Benefit plan administration and assignment plan rules will have to be added to ensure accurate selection of the potential assignment pool for the various health plans and to allow assignment for Medicaid beneficiaries that meet the plan enrollment criteria or the existence of any known diagnoses or disabilities. It is unclear which diagnoses or disabilities the agency would be required to take into account when making assignments into managed care plans. These additional assessment processes will require additional programming for the Medicaid enrollment and Choice Counseling vendors to incorporate into the Medicaid Reform auto-assignment process. Additional enrollment materials would need to be distributed to the recipients eligible to enroll in the specialty plan once the specialty plan becomes available. Therefore, additional resources would likely be needed.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not provide any rule making authority to the agency; however, the bill authorizes AHCA to develop and implement a definition of "psychiatric disabilities" and establish "assignment processes" for recipients with psychiatric disabilities who fail to choose a managed care plan in reform. AHCA has general rulemaking authority applicable to Medicaid reform provided for in s. 409.91211, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill at lines 91-92 references Medicaid recipients with "psychiatric disabilities." The term "psychiatric disabilities" is not defined; however, at lines 131-135, the bill authorizes AHCA to develop and implement a definition of "psychiatric disabilities" for purposes of the Medicaid reform pilot program. It is unclear what definition would apply to non-Medicaid reform areas.

According to AHCA, requiring AHCA to identify recipients with psychiatric disabilities in order to assign them to specialty PSNs would necessitate amendments to the Medicaid Reform Section 1115 Demonstration Waiver and the Section 1915(b) Managed Care Organization, Prepaid Inpatient Health Plan, Prepaid Ambulatory Health Plan, and Primary Care Case Management Waivers, which would require approval from CMS.[19] AHCA estimates that it could take four months to complete the waiver

[19] *Id.*

amendment process, which could delay the implementation of the bill.[20] It is unclear why an amendment would be required for the Medicaid Reform Section 1115 Demonstration Waiver. The current waiver does not specifically reference or preclude assignment by assessed needs. However, both the approved waiver application and the terms and conditions reference the auto-assignment criteria list as a minimum, authorizing additional (unnamed) criteria. In addition, assignment by needs assessment is required by current law.

AHCA anticipates that assignment of recipients with known diagnoses or disabilities could delay recipients' access to and enrollment into a health plan.[21] It is unclear why the bill should impact the 30-day plan choice period, as the bill's proposed automatic assignment to the non-reform specialty PSN is for recipients who fail to make a choice within the 30-day plan choice period. AHCA anticipates that for recipients in Medicaid reform areas, this delay could result in a beneficiary exceeding the statutory 30-day plan choice period, necessitating involuntary placement into a plan by Medicaid.[22] Again, it is unclear why the bill should impact the 30-day plan choice period, as the automatic assignment to the reform specialty PSN is for recipients who fail to make a choice within the 30-day plan choice period.

AHCA has also indicated that the provisions in lines 118-122 of the bill, which require a recipient with psychiatric disabilities being served in a non-Medicaid reform area be assigned to a specialty PSN if the recipient fails to select a managed care plan, and a specialty PSN is available in that geographic area, appear to conflict with s. 409.9122(k), F.S., which currently requires that recipients who fail to make a choice about managed care plans be assigned "equally" to MediPass or a managed care plan.[23] However, this language only applies to AHCA areas 1 and 6, not to all managed care assignments statewide. In addition, in SB 12C passed during Special Session C in 2007, the "equal" assignment language in s. 409.9122(k), F.S., was removed, thereby reverting those two AHCA areas to the statutory assignment scheme of assignment of all Medicaid recipients in non-reform areas who fail to choose a plan to be automatically enrolled in either managed care plans or fee-for-service Medicaid disproportionately to reach a ratio of 65 percent and 35 percent, respectively, pursuant to the remaining language in s. 409.9122(k), F.S. It is unclear how the mandatory assignment to a specialty PSN in the bill will interact with this assignment requirement.

Further, as discussed in the "Effect of Proposed Changes" section above, AHCA states that the bill does not indicate whether the specialty PSN will provide comprehensive health care.[24] In Medicaid reform areas, comprehensive health care includes behavioral health care for PSNs.[25] "In non-Medicaid reform counties, a specialty PSN will not be able to provide behavioral health care under existing law and will have to coordinate the behavioral health care with the competitively procured entities."[26]

D. STATEMENT OF THE SPONSOR

One of our greatest expectations from Medicaid reform, in addition to controlling future Medicaid expenditures, was to expand consumer choice of plans, increase competition among plans for Medicaid populations, develop programs that were customized for certain populations to promote better treatment outcomes, and improve plan accountability and value. We're still early in reform, but many of the plans are very much the same with the same benefit structures. With this bill, an entirely new choice would be available – a Specialty Provider Service Network for Medicaid beneficiaries with mental illness, a group accounting for the largest proportion of spending by disabled populations and a group that often has multiple co-morbid conditions and dies 20-25 years prematurely.

[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 11, 2008, the Health Innovation Committee adopted one strike-all amendment to the bill. This amendment:

- amends s. 409.912(4)(d), F.S., by requiring AHCA to seek and authorizing AHCA to accept applications for specialty provider service networks (PSNs) for recipients with psychiatric disabilities, to provide both behavioral and physical health services required for other Medicaid HMOs and PSNs;

- amends s. 409.912(4)(d), F.S., by providing that Medicaid recipient required but failing to select a managed care plan shall be assigned to such a specialty PSN if one is available in the recipient's geographic area;

- amends s. 409.912(4)(d), F.S., by expressly excepting the provisions of s. 409.912(4)(d)2., F.S., from the Medicaid provider service network recipient assignment provisions of s. 409.912(4)(d)1., F.S.;

- amends s. 409.912(4)(d), F.S., by providing that Medicaid recipients who meet diagnostic criteria indicating a mental illness or emotional disturbance, and Medicaid recipients served by Medicaid-enrolled community mental health agencies or who voluntarily choose the specialty PSN are presumed to meet the plan enrollment criteria;

- creates s. 409.91211(3)(ee), F.S., by requiring AHCA to develop and implement a service delivery alternative within capitated managed care plans in Medicaid reform counties to provide Medicaid services for persons with psychiatric disabilities sufficient to meet their medical, developmental and emotional needs;

- amends s. 409.91211(4), F.S., by requiring AHCA to assess the beneficiary's psychiatric disability and consider the extent of a Medicaid beneficiary's psychiatric disability in making assignment decisions for recipients who have not selected a managed care plan in Medicaid reform counties, and providing an express exemption from the current requirement that AHCA not engage in practices designed to favor one plan over another or encourage recipients to enroll in one plan rather than another in order to strengthen a plan's fiscal viability;

- amends s. 409.91211(4), F.S., by requiring AHCA to include in any enrollment and choice counseling materials an explanation of the choice of any specialty PSN or managed care plan in Medicaid reform counties;

- amends s. 409.91211(3)(aa), F.S., requiring AHCA, in making assignment decisions for Medicaid SSI recipients who fail to choose a managed care plan in Medicaid reform counties, to determine whether a Medicaid SSI recipient has an ongoing relationship with a community mental health provider and to assign the recipient there, if so, and, if not, to assign the recipient in accordance with s. 409.91211(4)(a)-(d), F.S., rather than in accordance with s. 409.9122, F.S.;

- amends s. 409.91211(3)(o), F.S., requiring AHCA to modify the "eligibility assignment process" as specified in s. 409.91211(3)(aa) in Medicaid reform counties; and

- amends s. 409.91211(4), F.S., requiring AHCA to offer an open enrollment period to beneficiaries meeting diagnostic criteria when a specialty PSN or specialty managed care plan first becomes available, during which they may choose to reenroll in the new specialty plan.

The bill was reported favorably with one amendment.