**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Children, Families, and Elder Affairs Committee

| | |
|---|---|
| BILL: | CS/SB 846 |
| INTRODUCER: | Children, Families, and Elder Affairs Committee and Senators Rich, Dean, and Dawson |
| SUBJECT: | Medicaid Provider Service Networks |
| DATE: | April 3, 2008 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Garner | Wilson | HP | **Favorable** |
| 2. | Ray | Jameson | CF | **Fav/CS** |
| 3. | | | HA | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## I. Summary:


Committee Substitute for Senate Bill 846 provides authority for the Agency for Health Care Administration (AHCA or "the agency") to contract with specialty provider service networks (PSNs) that will provide a comprehensive system of care to Medicaid recipients with psychiatric disabilities.

The bill defines the term "psychiatric disabilities."

The bill modifies the mandatory assignment process as it pertains to individuals who do not choose a managed care plan upon enrollment in Medicaid. The bill requires AHCA, in areas where a specialty PSN is established, to assign recipients who meet the diagnostic criteria or who have been served by community mental health agencies, and who fail to make a choice, to this specialty PSN. It also allows Medicaid recipients who do not meet the diagnostic criteria or have not been served by community mental health agencies to voluntarily enroll in the specialty PSN. When more than one capitated managed care network provider is available for assignments, AHCA must assess a recipient's psychiatric disability and take the assessment into consideration before making a mandatory assignment.

The bill requires AHCA to conduct a special open enrollment for all individuals who meet certain diagnostic criteria once a specialty PSN becomes operational in a geographic area and requires AHCA to include an explanation of the choice between a specialty PSN or specialty managed care plan in all enrollment and choice counseling materials provided by AHCA.

The bill amends ss. 409.912 and 409.91211, F.S.

## II. Present Situation:

**Incidence of Severe Mental Illness**
There is no standard definition of "mental illness." According to the U.S. Department of Health and Human Services, "mental illness" is a term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior or a combination thereof associated with distress or impaired functioning.[1]

Within this broad framework, some individuals are diagnosed with severe mental illnesses (SMI). Severe mental illnesses have several common features including:

- Disorders with psychotic features (e.g., schizophrenia, bipolar illness, etc.);
- Histories often significant for hospitalization or maintenance medication;
- Functional impairment present; and
- Impairment not due to the neuropsychiatric manifestations of HIV infection.

The Florida Mental Health Institute at the University of South Florida conducted a data run of the FY 2003-04 Medicaid eligibility file in order to estimate the proportion of Medicaid beneficiaries diagnosed with an SMI or severe emotional disturbance (SED). Based on this data run, the institute estimated that 4.85 percent of the total Medicaid population has an SMI or SED. Applying this percentage to FY 2007-08 unduplicated Medicaid eligibles would yield the following:[2]

Total Medicaid eligibles = 2,142,541

Total SED and SMI eligibles (4.85 percent of total population) = 103,913[3]

**Florida Medicaid Program**
Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The agency is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[4] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[5] Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or ch. 216, F.S.

---

[1] Mental Health: A Report to the Surgeon General. U.S. Health and Human Services. http://mentalhealth.samhsa.gov/features/surgeongeneralreport/chapter1/sec1.asp (last visited on March 27, 2008)
[2] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on March 27, 2008).
[3] Not all of these individuals would be eligible for participation in a Medicaid managed care plan.
[4] These mandatory services are codified in s. 409.905, F.S.
[5] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.

For FY 2008-09, the Florida Medicaid Program is projected to cover 2.25 million people[6] at an estimated cost of $15.8 billion.[7]

**Medicaid Managed Care Programs**

The state of Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to assign eligible beneficiaries[8] and, within specific areas of the state, to limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is broken into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program.

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and referral and authorization for specialty services and hospital care. The primary care providers are expected to monitor appropriateness of health care provided to their patients. MediPass providers receive a three dollar monthly case management fee for each of their enrolled patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered.

The second major category of provider in the Medicaid managed care program is the managed care plan. Section 409.9122, F.S., defines managed care plans as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), provider service networks (PSNs), minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs. These plans tend to be reimbursed through a capitated payment where the plan receives a set amount per member per month and is responsible for providing all necessary Medicaid services within that capitation rate.

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., AHCA is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not

[6] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on March 27, 2008).
[7] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on March 27, 2008).
[8] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

make a choice within 30 days of determination of eligibility. There are 23 counties with MediPass as the only managed care choice, ten counties have one managed care plan and MediPass, and 29 counties have at least two managed care plans in addition to MediPass.

As of January 2008, there were 2,107,427 individuals enrolled in the Florida Medicaid Program. Of these Medicaid recipients, 195,230 are enrolled in the Medicaid reform pilot and 1,912,197 are enrolled in the non-reform component of the program. Of those individuals not in the reform counties, 1,265,562 are eligible for mandatory managed care. Of the individuals eligible for mandatory managed care enrollment, they are enrolled in the following types of plans in these numbers: 362,505 are enrolled in MediPass; 586,361 are enrolled in HMOs; 117,523 are enrolled in minority physician networks; 24,274 are enrolled in the Children's Medical Services Network; 7,521 are enrolled in PSNs; and 6,258 are enrolled in pediatric emergency room diversion plans.

**Provider Service Networks**

The Florida Medicaid Program continually works to limit increases in the cost of medical care in the program, often through the use of managed care. A PSN is an integrated health care delivery system owned and operated by Florida hospitals and physician groups, as defined in s. 409.912(4)(d), F.S. The PSN is a Medicaid managed care option for Medicaid recipients, along with HMOs, MediPass, and the Children's Medical Services Network.

In Florida, the PSN component of Medicaid started as a demonstration project in 2002, based on a model in which a provider organization, or network of organizations, provides care to a defined population and also agrees to perform associated "insurance" functions, such as enrollee services, provider credentialing, claims processing, and quality assurance. The concept is built on an assumption that health care costs can be contained when money flows directly from payer to provider, removing the insurance "middle man" from the transaction.[9]

Florida's PSN program uses a fee-for-service approach, with established payment limits and a linkage between payments and quality of care on a series of performance indicators. Additionally, the pilot program required implementation of disease state management programs in order to control costs and enhance outcomes for those patients with predictably expensive conditions.

Under Medicaid reform, PSNs are allowed to participate alongside HMOs in Baker, Broward, Clay, Duval, and Nassau Counties. Section 409.91211, F.S. allows PSNs to bill fee-for-service for three years, but then they must transition to the same risk-adjusted capitation arrangements that apply to the HMOs.

Eligible Medicaid beneficiaries in the reform pilot counties may choose among the managed care plans in their county. Certain individuals were excluded from mandatory participation in Medicaid reform until service delivery alternatives were developed in the reform areas. These individuals include children with chronic medical conditions, children in foster care, and persons with developmental disabilities.

[9] Agency of Health Care Administration. http://www.fdhc.state.fl.us/Medicaid/quality_management/mrp/Projects/psn/index.shtml (last visited on March 27, 2008).

**Medicaid Prepaid Behavioral Health Plans**
In March 1996, AHCA implemented a Prepaid Mental Health Plan (PMHP) demonstration, under the authority of the 1915(b) Medicaid managed care waiver. The program was piloted for many years in two areas of the state before being expanded statewide in 2004, and is codified in s. 409.912(4), F.S.

A prepaid behavioral health plan is a managed care organization that contracts with AHCA to provide comprehensive mental health services to its members though a capitated payment system. The agency pays a per member, per month (PMPM) fee to the plan based on the age and eligibility category of each member. Services provided by these plans must include:

- Inpatient Psychiatric Hospital Services,
  - 45 days for adult recipients
  - 365 days for children
- Outpatient Psychiatric Hospital Services,
- Psychiatric Physician Services,
- Community Mental Health Services, and
- Mental Health Targeted Case Management.

Medicaid recipients who elect to enroll in MediPass for the provision of their physical health care services are assigned to a prepaid behavioral health plan for the provision of their mental health services, unless they are ineligible. Ineligible persons include:

- Recipients who have both Medicaid and Medicare coverage (dual eligibles),
- Persons living in an institutional setting, such as a nursing home, state mental health treatment facility, or prison,
- Medicaid-eligible recipients receiving services through hospice,
- Recipients in the Medically Needy Program,
- Newly enrolled recipients who have not yet chosen a health plan,
- SOBRA-eligible pregnant women and presumptively eligible pregnant women,
- Individuals with private major medical coverage,
- Members of a Medicaid HMO if the HMO has chosen to provide behavioral health services,
- Recipients receiving FACT services, and
- Children enrolled in the HomeSafeNet database, unless they are enrolled in a Medicaid reform managed care plan in Broward County.

Because of their unique situation, children in the HomeSafeNet database are excluded from participating in the prepaid behavioral health plan. A separate prepaid plan was developed for these children to provide services (including behavioral health services) operated by community based lead agencies as of July 1, 2005, that are contracted through the Department of Children and Family Services.

**Medicaid Reform**
On January 11, 2005, Governor Bush released a Medicaid reform proposal (originally called Empowered Care) for consideration by the Legislature. The proposal was based on data at the

time demonstrating that the Medicaid budget was growing at an unsustainable rate and that a comprehensive overhaul of the system was necessary to improve care and provide predictability in the state Medicaid budget.

The Governor's proposal centered on the concept of moving Medicaid recipients out of the current fee-for-service system into a mostly managed care environment. In this new system, managed care plans, including traditional Medicaid HMOs and new provider service networks (PSNs), will receive actuarially-sound, risk-adjusted capitation rates to provide all mandatory and optional services to Medicaid recipients.

The Legislature passed a Medicaid reform law in CS/CS/SB 838 (ch. 2005-133, L.O.F.), and the Medicaid reform pilot program is codified in s. 409.91211, F.S. The provisions of the law established a pilot program to be implemented in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties are required to select among a number of managed care plans and recipients are no longer eligible to select the MediPass program as a managed care option. Reform plans offer comprehensive, catastrophic and enhanced benefits which are allowed to vary within certain parameters from plan to plan. Medicaid recipients receive choice counseling to help them select among the plans.

Certain groups were excluded from mandatory participation in the reform pilot until specialty networks were developed to meet their needs. Specifically, the law prevented children with special health care needs, persons with developmental disabilities, and Medicaid-eligible children in foster care from being automatically enrolled into the managed care plans until AHCA could approve plans to meet their special needs.[10] To date, only specialty plans serving children with special health care needs have been approved to provide services under the reform initiative.

The law requires the Medicaid reform pilot to be evaluated by the Office of Program Policy Analysis and Government Accountability (OPPAGA). Their report is to be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than June 30, 2008. Medicaid reform may not be expanded beyond the initial pilot counties without the express permission of the Legislature.

## III. Effect of Proposed Changes:

**Section 1.**
The bill amends s. 409.912, F.S., to require AHCA to seek applications for and authorize contracts with specialty PSNs that exclusively enroll Medicaid beneficiaries who have psychiatric disabilities. The Medicaid specialty PSN must provide the full range of physical and behavioral health services that other Medicaid HMOs and PSNs are required to provide. Medicaid beneficiaries having psychiatric disabilities who are required but fail to select a managed care plan shall be assigned to the specialty PSN in those geographic areas where a specialty PSN is available. The bill also allows Medicaid recipients who do not meet the diagnostic criteria or have not been served by community mental health agencies to voluntarily enroll in the specialty PSN.

[10] Sections 409.91211(3)(bb)-(dd), F.S.

The bill provides that AHCA is not required to perform an assessment to determine whether an individual is eligible to enroll in a specialty PSN. The bill provides that the eligibility of a current beneficiary, with claims history, is based on current Medicaid data. The bill provides that nonchoosing, new beneficiaries without a claims history are not eligible for assignment to a specialty PSN. However, during the open enrollment period, a beneficiary's request to be assigned to a specialty PSN is sufficient for the agency to determine qualification for the specialty PSN.

The bill defines the term "psychiatric disability" as it is used in s. 409.912, F.S., to include:

- A person who suffers from schizophrenia, schizoaffective disorder, major depression, bipolar, manic and depressive disorders, delusional disorders, psychosis, conduct disorders, other emotional disturbances, attention deficit hyperactivity disorders, panic disorders, and obsessive-compulsive disorders; or
- A person who has met at least one of the following severity criteria within the last year: inpatient psychiatric hospitalization or use of antipsychotic medication.

**Section 2.**
The bill amends s. 409.91211, F.S., to require AHCA to assign individuals with psychiatric disabilities who do not choose a plan in the Medicaid reform pilot counties to enroll these individuals in a specialty PSN authorized in this act, if a specialty PSN for persons with psychiatric disabilities exists.

To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), the bill requires AHCA in the Medicaid reform pilot counties to include consideration of a new enrollee's ongoing relationship with a community mental health provider as part of the mandatory assignment process, and to assign these individuals to the same provider that includes the community mental health provider, where feasible.

The bill directs AHCA to develop and implement a service delivery alternative within the Medicaid reform pilot counties to provide Medicaid services as specified in ss. 409.905 (Mandatory Medicaid Services) and 409.906 (Optional Medicaid Services), F.S., for persons with psychiatric disabilities sufficient to meet their needs.

The bill also directs AHCA to generally assess and take into account the extent of the psychiatric disability of the Medicaid recipient before making any assignment to any managed care plan within the reform counties. The bill requires AHCA to include an explanation of the choice of any specialty PSN or specialty managed care plan in all enrollment and choice counseling materials provided by AHCA.

The bill clarifies that AHCA may not favor one managed care plan over another in the mandatory assignment process except as provided in this section related to persons with psychiatric disabilities.

The bill requires AHCA, when a specialty PSN or specialty managed care plan first becomes available in a geographic area, to offer an open enrollment period for all beneficiaries meeting

psychiatric diagnostic criteria. During this enrollment period, beneficiaries meeting psychiatric diagnostic criteria may choose to reenroll in a specialty PSN or specialty managed care plan.

**Section 3.**
The bill provides that this act takes effect July 1, 2008.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Many Medicaid services are currently provided to persons through private managed care entities, which include Medicaid HMOs and PSNs, both within and outside of the reform pilot counties. To the extent that the mandatory assignment process and open enrollment period required in this bill mandate AHCA to assign persons with these conditions into the specialty PSN or allow individuals to choose the new specialty PSNs, the existing plans will lose current and future revenue.

C. Government Sector Impact:

**Agency for Health Care Administration**
The bill authorizes AHCA to contract with a specialty PSN for recipients with psychiatric disabilities in both Medicaid Reform and non-reform areas. Due to the following issues, the fiscal impact cannot be determined at this time.

- For Medicaid reform areas, the next phase of Medicaid reform expansion has not been determined by the Florida Legislature; therefore, the number of recipients that 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 AHCA. Therefore, the number of counties for which the specialty PSN is awarded a contract in non-reform areas is unknown and the number

of affected non-reform enrollees that may be subject to enrollment in the non-reform model is unknown.
- Finally, the number of children in the HomeSafeNet system who may meet the enrollment criteria for the specialty PSN has not been assessed.

The revisions to the assignment process may cause a delay in managed care enrollment processes such that additional fee-for-service Medicaid expenditures may occur. The agency would need to develop 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 or voluntary enrollment for Medicaid beneficiaries that meet the plan enrollment criteria.

Additional open enrollment materials would need to be distributed to the recipients eligible to enroll in the specialty plan once the specialty plan becomes available.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**CS by Children, Families, and Elder Affairs on April 1, 2008:**
- Defines the term "psychiatric disability" consistent with s. 409.912, F.S.
- Clarifies AHCA's enrollment provisions relating to current beneficiaries and provides that AHCA is not required to perform an assessment to determine if an individual is eligible to enroll in a specialty PSN. The bill provides that the eligibility of a current beneficiary with a claims history, is based on current Medicaid data. The bill provides that nonchoosing, new beneficiaries without a claims history are not eligible for assignment to a specialty PSN. During the open enrollment period, a beneficiary's request to be assigned to a specialty PSN is sufficient for the agency to determine qualification for the specialty PSN.
- Removes the term "provider service network" from line 171 because it is included in the definition of capitated managed care plan in s. 409.91211(12), F.S.

B. Amendments:

None.