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LEGISLATIVE ACTION

Senate	.	House
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Floor: 2/RS/2R	.	
04/23/2009 05:22 PM	.	
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Senator Peaden moved the following:

Senate Amendment (with directory and title amendments)

Delete lines 780 - 830
and insert:
(4) The agency may contract with:
(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such ~~an~~ entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c), and must possess the clinical systems and operational competence to manage risk and provide comprehensive

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13 behavioral health care to Medicaid recipients. As used in this
14 paragraph, the term “comprehensive behavioral health care
15 services” means covered mental health and substance abuse
16 treatment services that are available to Medicaid recipients.
17 The secretary of the Department of Children and Family Services
18 shall approve ~~provisions of~~ procurements related to children in
19 the department’s care or custody before ~~prior to~~ enrolling such
20 children in a prepaid behavioral health plan. Any contract
21 awarded under this paragraph must be competitively procured. In
22 developing the behavioral health care prepaid plan procurement
23 document, the agency shall ensure that the procurement document
24 requires the contractor to develop and implement a plan to
25 ensure compliance with s. 394.4574 related to services provided
26 to residents of licensed assisted living facilities that hold a
27 limited mental health license. Except as provided in
28 subparagraph 8., and except in counties where the Medicaid
29 managed care pilot program is authorized pursuant to s.
30 409.91211, the agency shall seek federal approval to contract
31 with a single entity meeting these requirements to provide
32 comprehensive behavioral health care services to all Medicaid
33 recipients not enrolled in a Medicaid managed care plan
34 authorized under s. 409.91211 or a Medicaid health maintenance
35 organization in an AHCA area. In an AHCA area where the Medicaid
36 managed care pilot program is authorized pursuant to s.
37 409.91211 in one or more counties, the agency may procure a
38 contract with a single entity to serve the remaining counties as
39 an AHCA area or the remaining counties may be included with an
40 adjacent AHCA area and are ~~shall be~~ subject to this paragraph.
41 Each entity must offer a sufficient choice of providers in its

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42 network to ensure recipient access to care and the opportunity
43 to select a provider with whom they are satisfied. The network
44 shall include all public mental health hospitals. To ensure
45 unimpaired access to behavioral health care services by Medicaid
46 recipients, all contracts issued pursuant to this paragraph must
47 ~~shall~~ require 80 percent of the capitation paid to the managed
48 care plan, including health maintenance organizations, to be
49 expended for the provision of behavioral health care services.
50 If ~~In the event~~ the managed care plan expends less than 80
51 percent of the capitation paid ~~pursuant to this paragraph~~ for
52 the provision of behavioral health care services, the difference
53 shall be returned to the agency. The agency shall provide the
54 ~~managed care~~ plan with a certification letter indicating the
55 amount of capitation paid during each calendar year for ~~the~~
56 ~~provision of~~ behavioral health care services pursuant to this
57 section. The agency may reimburse for substance abuse treatment
58 services on a fee-for-service basis until the agency finds that
59 adequate funds are available for capitated, prepaid
60 arrangements.
61 1. By January 1, 2001, the agency shall modify the
62 contracts with the entities providing comprehensive inpatient
63 and outpatient mental health care services to Medicaid
64 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
65 Counties, to include substance abuse treatment services.
66 2. By July 1, 2003, the agency and the Department of
67 Children and Family Services shall execute a written agreement
68 that requires collaboration and joint development of all policy,
69 budgets, procurement documents, contracts, and monitoring plans
70 that have an impact on the state and Medicaid community mental

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71 health and targeted case management programs.
72 3. Except as provided in subparagraph 8., by July 1, 2006,
73 the agency and the Department of Children and Family Services
74 shall contract with managed care entities in each AHCA area
75 except area 6 or arrange to provide comprehensive inpatient and
76 outpatient mental health and substance abuse services through
77 capitated prepaid arrangements to all Medicaid recipients who
78 are eligible to participate in such plans under federal law and
79 regulation. In AHCA areas where eligible individuals number less
80 than 150,000, the agency shall contract with a single managed
81 care plan to provide comprehensive behavioral health services to
82 all recipients who are not enrolled in a Medicaid health
83 maintenance organization or a Medicaid capitated managed care
84 plan authorized under s. 409.91211. The agency may contract with
85 more than one comprehensive behavioral health provider to
86 provide care to recipients who are not enrolled in a Medicaid
87 capitated managed care plan authorized under s. 409.91211 or a
88 Medicaid health maintenance organization in AHCA areas where the
89 eligible population exceeds 150,000. In an AHCA area where the
90 Medicaid managed care pilot program is authorized pursuant to s.
91 409.91211 in one or more counties, the agency may procure a
92 contract with a single entity to serve the remaining counties as
93 an AHCA area or the remaining counties may be included with an
94 adjacent AHCA area and shall be subject to this paragraph.
95 Contracts for comprehensive behavioral health providers awarded
96 pursuant to this section shall be competitively procured. Both
97 for-profit and not-for-profit corporations are ~~shall be~~ eligible
98 to compete. Managed care plans contracting with the agency under
99 subsection (3) shall provide and receive payment for the same

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100 comprehensive behavioral health benefits as provided in AHCA
101 rules, including handbooks incorporated by reference. In AHCA
102 area 11, the agency shall contract with at least two
103 comprehensive behavioral health care providers to provide
104 behavioral health care to recipients in that area who are
105 enrolled in, or assigned to, the MediPass program. One of the
106 behavioral health care contracts must ~~shall~~ be with the existing
107 provider service network pilot project, as described in
108 paragraph (d), for the purpose of demonstrating the cost-
109 effectiveness of the provision of quality mental health services
110 through a public hospital-operated managed care model. Payment
111 shall be at an agreed-upon capitated rate to ensure cost
112 savings. Of the recipients in area 11 who are assigned to
113 MediPass under ~~the provisions of~~ s. 409.9122(2)(k), a minimum of
114 50,000 of those MediPass-enrolled recipients shall be assigned
115 to the existing provider service network in area 11 for their
116 behavioral care.
117 4. By October 1, 2003, the agency and the department shall
118 submit a plan to the Governor, the President of the Senate, and
119 the Speaker of the House of Representatives which provides for
120 the full implementation of capitated prepaid behavioral health
121 care in all areas of the state.
122 a. Implementation shall begin in 2003 in those AHCA areas
123 of the state where the agency is able to establish sufficient
124 capitation rates.
125 b. If the agency determines that the proposed capitation
126 rate in any area is insufficient to provide appropriate
127 services, the agency may adjust the capitation rate to ensure
128 that care will be available. The agency and the department may

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use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided ~~for~~ in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider may ~~shall~~ not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family

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158 Services in areas 1 and 6, and inpatient mental health providers
159 licensed pursuant to chapter 395 must be offered an opportunity
160 to accept or decline a contract to participate in any provider
161 network for prepaid behavioral health services.
162 8. All Medicaid-eligible children, except children in area
163 1 and children in Highlands County, Hardee County, Polk County,
164 or Manatee County of area 6, that ~~who~~ are open for child welfare
165 services in the HomeSafeNet system, shall receive their
166 behavioral health care services through a specialty prepaid plan
167 operated by community-based lead agencies ~~either~~ through a
168 single agency or formal agreements among several agencies. The
169 specialty prepaid plan must result in savings to the state
170 comparable to savings achieved in other Medicaid managed care
171 and prepaid programs. Such plan must provide mechanisms to
172 maximize state and local revenues. The specialty prepaid plan
173 shall be developed by the agency and the Department of Children
174 and Family Services. The agency may ~~is authorized to~~ seek ~~any~~
175 federal waivers to implement this initiative. Medicaid-eligible
176 children whose cases are open for child welfare services in the
177 HomeSafeNet system and who reside in AHCA area 10 are exempt
178 from the specialty prepaid plan upon the development of a
179 service delivery mechanism for children who reside in area 10 as
180 specified in s. 409.91211(3)(dd).
181 (14)(a) The agency shall operate or contract for the
182 operation of utilization management and incentive systems
183 designed to encourage cost-effective use of services and to
184 eliminate services that are medically unnecessary. The agency
185 shall track Medicaid provider prescription and billing patterns
186 and evaluate them against Medicaid medical necessity criteria

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187 and coverage and limitation guidelines adopted by rule. Medical
188 necessity determination requires that service be consistent with
189 symptoms or confirmed diagnosis of illness or injury under
190 treatment and not in excess of the patient’s needs. The agency
191 shall conduct reviews of provider exceptions to peer group norms
192 and shall, using statistical methodologies, provider profiling,
193 and analysis of billing patterns, detect and investigate
194 abnormal or unusual increases in billing or payment of claims
195 for Medicaid services and medically unnecessary provision of
196 services. Providers that demonstrate a pattern of submitting
197 claims for medically unnecessary services shall be referred to
198 the Medicaid program integrity unit for investigation. In its
199 annual report, required in s. 409.913, the agency shall report
200 on its efforts to control overutilization as described in this
201 paragraph.
202 (b) The agency shall develop a procedure for determining
203 whether health care providers and service vendors can provide
204 the Medicaid program using a business case that demonstrates
205 whether a particular good or service can offset the cost of
206 providing the good or service in an alternative setting or
207 through other means and therefore should receive a higher
208 reimbursement. The business case must include, but need not be
209 limited to:
210 1. A detailed description of the good or service to be
211 provided, a description and analysis of the agency’s current
212 performance of the service, and a rationale documenting how
213 providing the service in an alternative setting would be in the
214 best interest of the state, the agency, and its clients.
215 2. A cost-benefit analysis documenting the estimated

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216 specific direct and indirect costs, savings, performance
217 improvements, risks, and qualitative and quantitative benefits
218 involved in or resulting from providing the service. The cost-
219 benefit analysis must include a detailed plan and timeline
220 identifying all actions that must be implemented to realize
221 expected benefits. The Secretary of Health Care Administration
222 shall verify that all costs, savings, and benefits are valid and
223 achievable.
224 (c) If the agency determines that the increased
225 reimbursement is cost-effective, the agency shall recommend a
226 change in the reimbursement schedule for that particular good or
227 service. If, within 12 months after implementing any rate change
228 under this procedure, the agency determines that costs were not
229 offset by the increased reimbursement schedule, the agency may
230 revert to the former reimbursement schedule for the particular
231 good or service.
232 (17) An entity contracting on a prepaid or fixed-sum basis
233 shall meet the~~, in addition to meeting any applicable statutory~~
234 surplus requirements of s. 641.225~~, also maintain at all times~~
235 ~~in the form of cash, investments that mature in less than 180~~
236 ~~days allowable as admitted assets by the Office of Insurance~~
237 ~~Regulation, and restricted funds or deposits controlled by the~~
238 ~~agency or the Office of Insurance Regulation, a surplus amount~~
239 ~~equal to one-and-one-half times the entity's monthly Medicaid~~
240 ~~prepaid revenues~~. ~~As used in this subsection, the term "surplus"~~
241 ~~means the entity's total assets minus total liabilities.~~ If an
242 entity's surplus falls below an amount equal to the surplus
243 requirements of s. 641.225 ~~one-and-one-half times the entity's~~
244 ~~monthly Medicaid prepaid revenues~~, the agency shall prohibit the

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245 entity from engaging in marketing and preenrollment activities,
246 shall cease to process new enrollments, and may ~~shall~~ not renew
247 the entity's contract until the required balance is achieved.
248 ~~The requirements of this subsection do not apply:~~
249 ~~(a) Where a public entity agrees to fund any deficit~~
250 ~~incurred by the contracting entity; or~~
251 ~~(b) Where the entity's performance and obligations are~~
252 ~~guaranteed in writing by a guaranteeing organization which:~~
253 ~~1. Has been in operation for at least 5 years and has~~
254 ~~assets in excess of $50 million; or~~
255 ~~2. Submits a written guarantee acceptable to the agency~~
256 ~~which is irrevocable during the term of the contracting entity's~~
257 ~~contract with the agency and, upon termination of the contract,~~
258 ~~until the agency receives proof of satisfaction of all~~
259 ~~outstanding obligations incurred under the contract.~~
260
261 ====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
262 And the directory clause is amended as follows:
263 Delete lines 716 - 717
264 and insert:
265 Section 12. Paragraph (b) of subsection (4), subsection
266 (14), and subsection (17) of section 409.912, Florida Statutes,
267 are amended to read:
268
269 ================ T I T L E A M E N D M E N T ================
270 And the title is amended as follows:
271 Delete lines 49 - 53
272 and insert:
273 providers; amending s. 409.912, F.S.; requiring that

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274 certain entities that provide comprehensive behavioral
275 health care services to certain Medicaid recipients be
276 licensed or authorized; requiring the Agency for
277 Health Care Administration to establish norms for the
278 utilization of Medicaid services; requiring the agency
279 to submit a report relating to the overutilization of
280 Medicaid services; revising the requirement for an
281 entity that contracts on a prepaid or fixed-sum basis
282 to meet certain surplus requirements; deleting the
283 requirement that an entity maintain certain
284 investments and restricted funds or deposits; revising
285 the circumstances in which the agency must prohibit
286 the entity from engaging in certain activities, cease
287 to process new enrollments, and not renew the entity’s
288 contract; deleting certain exemptions; amending s.