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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/01/2009	.	
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The Committee on Health Regulation (Altman) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3
4 Delete everything after the enacting clause
5 and insert:
6 Section 1. Paragraph (b) of subsection (4) of section
7 409.912, Florida Statutes, is amended to read:
8 409.912 Cost-effective purchasing of health care.—The
9 agency shall purchase goods and services for Medicaid recipients
10 in the most cost-effective manner consistent with the delivery
11 of quality medical care. To ensure that medical services are

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12 effectively utilized, the agency may, in any case, require a
13 confirmation or second physician's opinion of the correct
14 diagnosis for purposes of authorizing future services under the
15 Medicaid program. This section does not restrict access to
16 emergency services or poststabilization care services as defined
17 in 42 C.F.R. part 438.114. Such confirmation or second opinion
18 shall be rendered in a manner approved by the agency. The agency
19 shall maximize the use of prepaid per capita and prepaid
20 aggregate fixed-sum basis services when appropriate and other
21 alternative service delivery and reimbursement methodologies,
22 including competitive bidding pursuant to s. 287.057, designed
23 to facilitate the cost-effective purchase of a case-managed
24 continuum of care. The agency shall also require providers to
25 minimize the exposure of recipients to the need for acute
26 inpatient, custodial, and other institutional care and the
27 inappropriate or unnecessary use of high-cost services. The
28 agency shall contract with a vendor to monitor and evaluate the
29 clinical practice patterns of providers in order to identify
30 trends that are outside the normal practice patterns of a
31 provider's professional peers or the national guidelines of a
32 provider's professional association. The vendor must be able to
33 provide information and counseling to a provider whose practice
34 patterns are outside the norms, in consultation with the agency,
35 to improve patient care and reduce inappropriate utilization.
36 The agency may mandate prior authorization, drug therapy
37 management, or disease management participation for certain
38 populations of Medicaid beneficiaries, certain drug classes, or
39 particular drugs to prevent fraud, abuse, overuse, and possible
40 dangerous drug interactions. The Pharmaceutical and Therapeutics

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41 Committee shall make recommendations to the agency on drugs for
42 which prior authorization is required. The agency shall inform
43 the Pharmaceutical and Therapeutics Committee of its decisions
44 regarding drugs subject to prior authorization. The agency is
45 authorized to limit the entities it contracts with or enrolls as
46 Medicaid providers by developing a provider network through
47 provider credentialing. The agency may competitively bid single-
48 source-provider contracts if procurement of goods or services
49 results in demonstrated cost savings to the state without
50 limiting access to care. The agency may limit its network based
51 on the assessment of beneficiary access to care, provider
52 availability, provider quality standards, time and distance
53 standards for access to care, the cultural competence of the
54 provider network, demographic characteristics of Medicaid
55 beneficiaries, practice and provider-to-beneficiary standards,
56 appointment wait times, beneficiary use of services, provider
57 turnover, provider profiling, provider licensure history,
58 previous program integrity investigations and findings, peer
59 review, provider Medicaid policy and billing compliance records,
60 clinical and medical record audits, and other factors. Providers
61 shall not be entitled to enrollment in the Medicaid provider
62 network. The agency shall determine instances in which allowing
63 Medicaid beneficiaries to purchase durable medical equipment and
64 other goods is less expensive to the Medicaid program than long-
65 term rental of the equipment or goods. The agency may establish
66 rules to facilitate purchases in lieu of long-term rentals in
67 order to protect against fraud and abuse in the Medicaid program
68 as defined in s. 409.913. The agency may seek federal waivers
69 necessary to administer these policies.

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70 (4) The agency may contract with:
71 (b) An entity that is providing comprehensive behavioral
72 health care services to ~~certain~~ Medicaid recipients through a
73 capitated, prepaid arrangement pursuant to the federal waiver
74 authorized in ~~provided for by~~ s. 409.905(5). Such an entity must
75 be licensed under chapter 624, chapter 636, or chapter 641 and
76 must possess the clinical systems and operational competence to
77 manage risk and provide comprehensive behavioral health care to
78 Medicaid recipients. As used in this paragraph, the term
79 "comprehensive behavioral health care services" means covered
80 mental health and substance abuse treatment services that are
81 available to Medicaid recipients. The secretary of the
82 Department of Children and Family Services must ~~shall~~ approve
83 ~~provisions of~~ procurements related to children in the
84 department's care or custody before ~~prior to~~ enrolling such
85 children in a prepaid behavioral health plan. Any contract
86 awarded under this paragraph must be competitively procured. In
87 developing the behavioral health care prepaid plan procurement
88 document, the agency shall ensure that the ~~procurement~~ document
89 requires the contractor to develop and implement a plan to
90 ensure compliance with s. 394.4574 related to services provided
91 to residents of licensed assisted living facilities that hold a
92 limited mental health license. Except as provided in
93 subparagraph 8., and except in counties where the Medicaid
94 managed care pilot program is authorized pursuant to s.
95 409.91211, the agency shall seek federal approval to contract
96 with a single entity meeting these requirements to provide
97 comprehensive behavioral health care services to all Medicaid
98 recipients not enrolled in a Medicaid managed care plan

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99 authorized under s. 409.91211 or a Medicaid health maintenance
100 organization in an AHCA area. In an AHCA area where the Medicaid
101 managed care pilot program is authorized pursuant to s.
102 409.91211 in one or more counties, the agency may procure a
103 contract with a single entity to serve the remaining counties as
104 an AHCA area or the remaining counties may be included with an
105 adjacent AHCA area and are ~~shall be~~ subject to this paragraph.
106 Each entity must offer a sufficient choice of providers in its
107 network to ensure recipient access to care and the opportunity
108 to select a provider with whom they are satisfied. The network
109 shall include all public mental health hospitals. ~~To ensure~~
110 ~~unimpaired access to behavioral health care services by Medicaid~~
111 ~~recipients, all contracts issued pursuant to this paragraph~~
112 ~~shall require 80 percent of the capitation paid to the managed~~
113 ~~care plan, including health maintenance organizations, to be~~
114 ~~expended for the provision of behavioral health care services.~~
115 ~~In the event the managed care plan expends less than 80 percent~~
116 ~~of the capitation paid pursuant to this paragraph for the~~
117 ~~provision of behavioral health care services, the difference~~
118 ~~shall be returned to the agency. The agency shall provide the~~
119 ~~managed care plan with a certification letter indicating the~~
120 ~~amount of capitation paid during each calendar year for the~~
121 ~~provision of behavioral health care services pursuant to this~~
122 ~~section.~~ The agency may reimburse for substance abuse treatment
123 services on a fee-for-service basis until the agency finds that
124 adequate funds are available for capitated, prepaid
125 arrangements.
126 1. By January 1, 2001, the agency shall modify the
127 contracts with the entities providing comprehensive inpatient

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128 and outpatient mental health care services to Medicaid
129 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
130 Counties, to include substance abuse treatment services.
131 2. By July 1, 2003, the agency and the department ~~of~~
132 ~~Children and Family Services~~ shall execute a written agreement
133 that requires collaboration and joint development of all policy,
134 budgets, procurement documents, contracts, and monitoring plans
135 that have an impact on the state and Medicaid community mental
136 health and targeted case management programs.
137 3. Except as provided in subparagraph 8., by July 1, 2006,
138 the agency and the department ~~of Children and Family Services~~
139 shall contract with managed care entities in each AHCA area
140 except area 6 or arrange to provide comprehensive inpatient and
141 outpatient mental health and substance abuse services through
142 capitated prepaid arrangements to all Medicaid recipients who
143 are eligible to participate in such plans under federal law and
144 regulation. In AHCA areas where eligible individuals number less
145 than 150,000, the agency shall contract with a single managed
146 care plan to provide comprehensive behavioral health services to
147 all recipients who are not enrolled in a Medicaid health
148 maintenance organization or a Medicaid capitated managed care
149 plan authorized under s. 409.91211. The agency may contract with
150 more than one comprehensive behavioral health provider to
151 provide care to recipients who are not enrolled in a Medicaid
152 capitated managed care plan authorized under s. 409.91211 or a
153 Medicaid health maintenance organization in AHCA areas where the
154 eligible population exceeds 150,000. In an AHCA area where the
155 Medicaid managed care pilot program is authorized pursuant to s.
156 409.91211 in one or more counties, the agency may procure a

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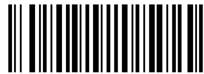
157 contract with a single entity to serve the remaining counties as
158 an AHCA area or the remaining counties may be included with an
159 adjacent AHCA area and are ~~shall be~~ subject to this paragraph.
160 Contracts for comprehensive behavioral health providers awarded
161 pursuant to this section must ~~shall~~ be competitively procured.
162 Both for-profit and not-for-profit corporations are ~~shall be~~
163 eligible to compete. Managed care plans contracting with the
164 agency under subsection (3) shall provide and receive payment
165 for the same comprehensive behavioral health benefits as
166 provided in AHCA rules, including handbooks incorporated by
167 reference. In AHCA area 11, the agency shall contract with at
168 least two comprehensive behavioral health care providers to
169 provide behavioral health care to recipients in that area who
170 are enrolled in, or assigned to, the MediPass program. One of
171 the behavioral health care contracts must ~~shall~~ be with the
172 existing provider service network pilot project, as described in
173 paragraph (d), for the purpose of demonstrating the cost-
174 effectiveness of the provision of quality mental health services
175 through a public hospital-operated managed care model. Payment
176 shall be at an agreed-upon capitated rate to ensure cost
177 savings. Of the recipients in area 11 who are assigned to
178 MediPass under the provisions of s. 409.9122(2)(k), a minimum of
179 50,000 of those MediPass-enrolled recipients shall be assigned
180 to the existing provider service network in area 11 for their
181 behavioral care.
182 4. By October 1, 2003, the agency and the department shall
183 submit a plan to the Governor, the President of the Senate, and
184 the Speaker of the House of Representatives which provides for
185 the full implementation of capitated prepaid behavioral health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186 care in all areas of the state.
187 a. Implementation shall begin in 2003 in those AHCA areas
188 of the state where the agency is able to establish sufficient
189 capitation rates.
190 b. If the agency determines that the proposed capitation
191 rate in any area is insufficient to provide appropriate
192 services, the agency may adjust the ~~capitation~~ rate to ensure
193 that care is ~~will be~~ available. The agency and the department
194 may use existing general revenue to address any additional
195 required match but may not over-obligate existing funds on an
196 annualized basis.
197 c. Subject to any limitations provided for in the General
198 Appropriations Act, the agency, in compliance with appropriate
199 federal authorization, shall develop policies and procedures
200 that allow for certification of local and state funds.
201 5. Children residing in a statewide inpatient psychiatric
202 program, or in a Department of Juvenile Justice or a Department
203 of Children and Family Services residential program approved as
204 a Medicaid behavioral health overlay services provider may ~~shall~~
205 not be included in a behavioral health care prepaid health plan
206 or any other Medicaid managed care plan pursuant to this
207 paragraph.
208 6. In converting to a prepaid system of delivery, the
209 agency shall in its procurement document require an entity
210 providing only comprehensive behavioral health care services to
211 prevent the displacement of indigent care patients by enrollees
212 in the Medicaid prepaid health plan providing behavioral health
213 care services from facilities receiving state funding to provide
214 indigent behavioral health care, to facilities licensed under

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215 chapter 395 which do not receive state funding for indigent
216 behavioral health care, or reimburse the unsubsidized facility
217 for the cost of behavioral health care provided to the displaced
218 indigent care patient.
219 7. Traditional community mental health providers under
220 contract with the department ~~of Children and Family Services~~
221 pursuant to part IV of chapter 394, child welfare providers
222 under contract with the department ~~of Children and Family~~
223 ~~Services~~ in areas 1 and 6, and inpatient mental health providers
224 licensed pursuant to chapter 395 must be offered an opportunity
225 to accept or decline a contract to participate in any provider
226 network for prepaid behavioral health services.
227 8. All Medicaid-eligible children, except children in area
228 1 and children in Highlands County, Hardee County, Polk County,
229 or Manatee County of area 6, who are open for child welfare
230 services in the HomeSafeNet system, shall receive their
231 behavioral health care services through a specialty prepaid plan
232 operated by community-based lead agencies ~~either~~ through a
233 single agency or formal agreements among several agencies. The
234 specialty prepaid plan must result in savings to the state
235 comparable to savings achieved in other Medicaid managed care
236 and prepaid programs. Such plan must provide mechanisms to
237 maximize state and local revenues. The specialty prepaid plan
238 shall be developed by the agency and the department ~~of Children~~
239 ~~and Family Services~~. The agency may ~~is authorized to~~ seek any
240 federal waivers to implement this initiative. Medicaid-eligible
241 children whose cases are open for child welfare services in the
242 HomeSafeNet system and who reside in AHCA area 10 are exempt
243 from the specialty prepaid plan upon the development of a

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244 service delivery mechanism for children who reside in area 10 as
245 specified in s. 409.91211(3)(dd).
246 9. To ensure unimpaired access to behavioral health care
247 services by Medicaid recipients, all contracts issued pursuant
248 to this paragraph must require that 80 percent of the capitation
249 paid to the managed care plan, including health maintenance
250 organizations, be expended for the provision of behavioral
251 health care services. If the plan expends less than 80 percent,
252 the difference must be returned to the agency and deposited into
253 the Medical Care Trust Fund. The agency shall maintain a
254 separate accounting of repayments deposited into the trust fund.
255 Repayments, minus federal matching funds that must be returned
256 to the Federal Government, shall be allocated to community
257 behavioral health providers enrolled in the networks of the
258 managed care organizations that made the repayments. Funds shall
259 be allocated in proportion to each community behavioral health
260 agency's earnings from the managed care organization making the
261 repayment. Providers shall use the funds for any Medicaid-
262 allowable type of community behavioral health and case
263 management service. Community agencies shall be reimbursed by
264 the agency on a fee-for-service basis for allowable services up
265 to their redistribution amount as determined by the agency.
266 Reinvestment amounts must be calculated on an annual basis,
267 within 60 days after health plans file their annual 80-percent
268 spending reports. The agency shall provide the managed care plan
269 with a certification letter indicating the amount of capitation
270 paid during each calendar year for the provision of behavioral
271 health care services pursuant to this section.
272 Section 2. This act shall take effect upon becoming a law.

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274 ================= T I T L E A M E N D M E N T ================

275 And the title is amended as follows:

276 Delete everything before the enacting clause

277 and insert:

278 A bill to be entitled

279 An act relating to Medicaid; amending s. 409.912,

280 F.S.; requiring that funds repaid to the Agency for

281 Health Care Administration by managed care plans that

282 spend less than a certain percentage of the capitation

283 rate for behavioral health services be deposited into

284 the Medical Care Trust Fund; providing that such

285 repayments be allocated to community behavioral health

286 providers and used for Medicaid behavioral and case

287 management services; providing an effective date.