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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2010	.	
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The Committee on Health and Human Services Appropriations (Haridopolos) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Between lines 811 and 812
4 insert:
5
6 Section 3. Paragraph (b) of subsection (4) of section
7 409.912, Florida Statutes, is amended, and paragraph (d) of
8 subsection (4) of that section is republished, to read:
9 409.912 Cost-effective purchasing of health care.—The
10 agency shall purchase goods and services for Medicaid recipients
11 in the most cost-effective manner consistent with the delivery
12 of quality medical care. To ensure that medical services are

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

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

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

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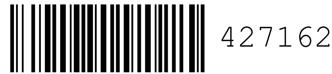
100 authorized under s. 409.91211, a provider service network
101 authorized under s. 409.912(4)(d), or a Medicaid health
102 maintenance organization in an AHCA area. In an AHCA area where
103 the Medicaid managed care pilot program is authorized pursuant
104 to s. 409.91211 in one or more counties, the agency may procure
105 a contract with a single entity to serve the remaining counties
106 as an AHCA area or the remaining counties may be included with
107 an adjacent AHCA area and are subject to this paragraph. Each
108 entity must offer a sufficient choice of providers in its
109 network to ensure recipient access to care and the opportunity
110 to select a provider with whom they are satisfied. The network
111 shall include all public mental health hospitals. To ensure
112 unimpaired access to behavioral health care services by Medicaid
113 recipients, all contracts issued pursuant to this paragraph must
114 require 80 percent of the capitation paid to the managed care
115 plan, including health maintenance organizations and capitated
116 provider service networks, to be expended for the provision of
117 behavioral health care services. If the managed care plan
118 expends less than 80 percent of the capitation paid for the
119 provision of behavioral health care services, the difference
120 shall be returned to the agency. The agency shall provide the
121 plan with a certification letter indicating the amount of
122 capitation paid during each calendar year for behavioral health
123 care services pursuant to this section. The agency may reimburse
124 for substance abuse treatment services on a fee-for-service
125 basis until the agency finds that adequate funds are available
126 for capitated, prepaid arrangements.
127 1. By January 1, 2001, the agency shall modify the
128 contracts with the entities providing comprehensive inpatient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129 and outpatient mental health care services to Medicaid
130 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
131 Counties, to include substance abuse treatment services.
132 2. By July 1, 2003, the agency and the Department of
133 Children and Family Services shall execute a written agreement
134 that requires collaboration and joint development of all policy,
135 budgets, procurement documents, contracts, and monitoring plans
136 that have an impact on the state and Medicaid community mental
137 health and targeted case management programs.
138 3. Except as provided in subparagraph 8., by July 1, 2006,
139 the agency and the Department of Children and Family Services
140 shall contract with managed care entities in each AHCA area
141 except area 6 or arrange to provide comprehensive inpatient and
142 outpatient mental health and substance abuse services through
143 capitated prepaid arrangements to all Medicaid recipients who
144 are eligible to participate in such plans under federal law and
145 regulation. In AHCA areas where eligible individuals number less
146 than 150,000, the agency shall contract with a single managed
147 care plan to provide comprehensive behavioral health services to
148 all recipients who are not enrolled in a Medicaid health
149 maintenance organization, a provider service network authorized
150 under s. 409.912(4)(d), or a Medicaid capitated managed care
151 plan authorized under s. 409.91211. The agency may contract with
152 more than one comprehensive behavioral health provider to
153 provide care to recipients who are not enrolled in a Medicaid
154 capitated managed care plan authorized under s. 409.91211, a
155 provider service network authorized under s. 409.912(4)(d), or a
156 Medicaid health maintenance organization in AHCA areas where the
157 eligible population exceeds 150,000. In an AHCA area where the

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158 Medicaid managed care pilot program is authorized pursuant to s.
159 409.91211 in one or more counties, the agency may procure a
160 contract with a single entity to serve the remaining counties as
161 an AHCA area or the remaining counties may be included with an
162 adjacent AHCA area and shall be subject to this paragraph.
163 Contracts for comprehensive behavioral health providers awarded
164 pursuant to this section shall be competitively procured. Both
165 for-profit and not-for-profit corporations are eligible to
166 compete. Managed care plans contracting with the agency under
167 subsection (3) or s. 409.912(4)(d), shall provide and receive
168 payment for the same comprehensive behavioral health benefits as
169 provided in AHCA rules, including handbooks incorporated by
170 reference. In AHCA area 11, the agency shall contract with at
171 least two comprehensive behavioral health care providers to
172 provide behavioral health care to recipients in that area who
173 are enrolled in, or assigned to, the MediPass program. One of
174 the behavioral health care contracts must be with the existing
175 provider service network pilot project, as described in
176 paragraph (d), for the purpose of demonstrating the cost-
177 effectiveness of the provision of quality mental health services
178 through a public hospital-operated managed care model. Payment
179 shall be at an agreed-upon capitated rate to ensure cost
180 savings. Of the recipients in area 11 who are assigned to
181 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
182 MediPass-enrolled recipients shall be assigned to the existing
183 provider service network in area 11 for their behavioral care.
184 4. By October 1, 2003, the agency and the department shall
185 submit a plan to the Governor, the President of the Senate, and
186 the Speaker of the House of Representatives which provides for

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187 the full implementation of capitated prepaid behavioral health
188 care in all areas of the state.
189 a. Implementation shall begin in 2003 in those AHCA areas
190 of the state where the agency is able to establish sufficient
191 capitation rates.
192 b. If the agency determines that the proposed capitation
193 rate in any area is insufficient to provide appropriate
194 services, the agency may adjust the capitation rate to ensure
195 that care will be available. The agency and the department may
196 use existing general revenue to address any additional required
197 match but may not over-obligate existing funds on an annualized
198 basis.
199 c. Subject to any limitations provided in the General
200 Appropriations Act, the agency, in compliance with appropriate
201 federal authorization, shall develop policies and procedures
202 that allow for certification of local and state funds.
203 5. Children residing in a statewide inpatient psychiatric
204 program, or in a Department of Juvenile Justice or a Department
205 of Children and Family Services residential program approved as
206 a Medicaid behavioral health overlay services provider may not
207 be included in a behavioral health care prepaid health plan or
208 any other Medicaid managed care plan pursuant to this paragraph.
209 6. In converting to a prepaid system of delivery, the
210 agency shall in its procurement document require an entity
211 providing only comprehensive behavioral health care services to
212 prevent the displacement of indigent care patients by enrollees
213 in the Medicaid prepaid health plan providing behavioral health
214 care services from facilities receiving state funding to provide
215 indigent behavioral health care, to facilities licensed under

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

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245 delivery mechanism for children who reside in area 10 as
246 specified in s. 409.91211(3)(dd).
247 (d) A provider service network may be reimbursed on a fee-
248 for-service or prepaid basis. A provider service network which
249 is reimbursed by the agency on a prepaid basis shall be exempt
250 from parts I and III of chapter 641, but must comply with the
251 solvency requirements in s. 641.2261(2) and meet appropriate
252 financial reserve, quality assurance, and patient rights
253 requirements as established by the agency. Medicaid recipients
254 assigned to a provider service network shall be chosen equally
255 from those who would otherwise have been assigned to prepaid
256 plans and MediPass. The agency is authorized to seek federal
257 Medicaid waivers as necessary to implement the provisions of
258 this section. Any contract previously awarded to a provider
259 service network operated by a hospital pursuant to this
260 subsection shall remain in effect for a period of 3 years
261 following the current contract expiration date, regardless of
262 any contractual provisions to the contrary. A provider service
263 network is a network established or organized and operated by a
264 health care provider, or group of affiliated health care
265 providers, including minority physician networks and emergency
266 room diversion programs that meet the requirements of s.
267 409.91211, which provides a substantial proportion of the health
268 care items and services under a contract directly through the
269 provider or affiliated group of providers and may make
270 arrangements with physicians or other health care professionals,
271 health care institutions, or any combination of such individuals
272 or institutions to assume all or part of the financial risk on a
273 prospective basis for the provision of basic health services by

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274 the physicians, by other health professionals, or through the
275 institutions. The health care providers must have a controlling
276 interest in the governing body of the provider service network
277 organization.
278
279
280 ================= T I T L E A M E N D M E N T ================
281 And the title is amended as follows:
282
283 Delete line 29
284 and insert:
285
286 certain information on its website; amending s.
287 409.912, F.S.; authorizing the Agency for Health Care
288 Administration to contract with an entity that
289 provides comprehensive behavioral health care services
290 to certain Medicaid recipients who are not enrolled in
291 a Medicaid managed care plan or a Medicaid provider
292 service network under certain circumstances; providing
293 an