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1 A bill to be entitled
2 An act relating to Medicaid; amending s. 409.912, F.S.;
3 requiring that funds repaid to the Agency for Health Care
4 Administration by managed care plans that spend less than
5 a certain percentage of the capitation rate for behavioral
6 health services be deposited into the Medical Care Trust
7 Fund; providing that such repayments be allocated to
8 community behavioral health providers and used for
9 Medicaid behavioral and case management services;
10 providing an effective date.

11
12 Be It Enacted by the Legislature of the State of Florida:

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14 Section 1. Paragraph (b) of subsection (4) of section
15 409.912, Florida Statutes, is amended to read:

16 409.912 Cost-effective purchasing of health care.—The
17 agency shall purchase goods and services for Medicaid recipients
18 in the most cost-effective manner consistent with the delivery
19 of quality medical care. To ensure that medical services are
20 effectively utilized, the agency may, in any case, require a
21 confirmation or second physician's opinion of the correct
22 diagnosis for purposes of authorizing future services under the
23 Medicaid program. This section does not restrict access to
24 emergency services or poststabilization care services as defined
25 in 42 C.F.R. part 438.114. Such confirmation or second opinion
26 shall be rendered in a manner approved by the agency. The agency
27 shall maximize the use of prepaid per capita and prepaid
28 aggregate fixed-sum basis services when appropriate and other

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29 | alternative service delivery and reimbursement methodologies,
30 | including competitive bidding pursuant to s. 287.057, designed
31 | to facilitate the cost-effective purchase of a case-managed
32 | continuum of care. The agency shall also require providers to
33 | minimize the exposure of recipients to the need for acute
34 | inpatient, custodial, and other institutional care and the
35 | inappropriate or unnecessary use of high-cost services. The
36 | agency shall contract with a vendor to monitor and evaluate the
37 | clinical practice patterns of providers in order to identify
38 | trends that are outside the normal practice patterns of a
39 | provider's professional peers or the national guidelines of a
40 | provider's professional association. The vendor must be able to
41 | provide information and counseling to a provider whose practice
42 | patterns are outside the norms, in consultation with the agency,
43 | to improve patient care and reduce inappropriate utilization.
44 | The agency may mandate prior authorization, drug therapy
45 | management, or disease management participation for certain
46 | populations of Medicaid beneficiaries, certain drug classes, or
47 | particular drugs to prevent fraud, abuse, overuse, and possible
48 | dangerous drug interactions. The Pharmaceutical and Therapeutics
49 | Committee shall make recommendations to the agency on drugs for
50 | which prior authorization is required. The agency shall inform
51 | the Pharmaceutical and Therapeutics Committee of its decisions
52 | regarding drugs subject to prior authorization. The agency is
53 | authorized to limit the entities it contracts with or enrolls as
54 | Medicaid providers by developing a provider network through
55 | provider credentialing. The agency may competitively bid single-
56 | source-provider contracts if procurement of goods or services

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57 results in demonstrated cost savings to the state without
58 limiting access to care. The agency may limit its network based
59 on the assessment of beneficiary access to care, provider
60 availability, provider quality standards, time and distance
61 standards for access to care, the cultural competence of the
62 provider network, demographic characteristics of Medicaid
63 beneficiaries, practice and provider-to-beneficiary standards,
64 appointment wait times, beneficiary use of services, provider
65 turnover, provider profiling, provider licensure history,
66 previous program integrity investigations and findings, peer
67 review, provider Medicaid policy and billing compliance records,
68 clinical and medical record audits, and other factors. Providers
69 shall not be entitled to enrollment in the Medicaid provider
70 network. The agency shall determine instances in which allowing
71 Medicaid beneficiaries to purchase durable medical equipment and
72 other goods is less expensive to the Medicaid program than long-
73 term rental of the equipment or goods. The agency may establish
74 rules to facilitate purchases in lieu of long-term rentals in
75 order to protect against fraud and abuse in the Medicaid program
76 as defined in s. 409.913. The agency may seek federal waivers
77 necessary to administer these policies.

78 (4) The agency may contract with:

79 (b) An entity that is providing comprehensive behavioral
80 health care services to ~~certain~~ Medicaid recipients through a
81 capitated, prepaid arrangement pursuant to the federal waiver
82 authorized in ~~provided for by~~ s. 409.905(5). Such entity must be
83 licensed under chapter 624, chapter 636, or chapter 641, or
84 authorized under paragraph (c), and must possess the clinical

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85 systems and operational competence to manage risk and provide
86 comprehensive behavioral health care to Medicaid recipients. As
87 used in this paragraph, the term "comprehensive behavioral
88 health care services" means covered mental health and substance
89 abuse treatment services that are available to Medicaid
90 recipients. The Secretary of ~~the Department of~~ Children and
91 Family Services must ~~shall~~ approve ~~provisions of~~ procurements
92 related to children in the department's care or custody before
93 enrolling such children in a prepaid behavioral health plan. Any
94 contract awarded under this paragraph must be competitively
95 procured. In developing the behavioral health care prepaid plan
96 procurement document, the agency shall ensure that the
97 ~~procurement~~ document requires the contractor to develop and
98 implement a plan that ensures ~~to ensure~~ compliance with s.
99 394.4574 related to ~~services provided to~~ residents of licensed
100 assisted living facilities that hold a limited mental health
101 license. Except as provided in subparagraph 8., and except in
102 counties where the Medicaid managed care pilot program is
103 authorized pursuant to s. 409.91211, the agency shall seek
104 federal approval to contract with a single entity meeting these
105 requirements to provide comprehensive behavioral health care
106 services to all Medicaid recipients not enrolled in a Medicaid
107 managed care plan authorized under s. 409.91211 or a Medicaid
108 health maintenance organization in an AHCA area. In an AHCA area
109 where the Medicaid managed care pilot program is authorized
110 pursuant to s. 409.91211 in one or more counties, the agency may
111 procure a contract with a single entity to serve the remaining
112 counties as an AHCA area or the remaining counties may be

113 included with an adjacent AHCA area and are subject to this
114 paragraph. Each entity must offer a sufficient choice of
115 providers in its network to ensure recipient access to care and
116 the opportunity to select a provider with whom they are
117 satisfied. The network must ~~shall~~ include all public mental
118 health hospitals. ~~To ensure unimpaired access to behavioral~~
119 ~~health care services by Medicaid recipients, all contracts~~
120 ~~issued pursuant to this paragraph must require 80 percent of the~~
121 ~~capitation paid to the managed care plan, including health~~
122 ~~maintenance organizations, to be expended for the provision of~~
123 ~~behavioral health care services. If the managed care plan~~
124 ~~expends less than 80 percent of the capitation paid for the~~
125 ~~provision of behavioral health care services, the difference~~
126 ~~shall be returned to the agency. The agency shall provide the~~
127 ~~plan with a certification letter indicating the amount of~~
128 ~~capitation paid during each calendar year for behavioral health~~
129 ~~care services pursuant to this section. The agency may reimburse~~
130 for substance abuse treatment services on a fee-for-service
131 basis until the agency finds that adequate funds are available
132 for capitated, prepaid arrangements.

133 1. By January 1, 2001, the agency shall modify the
134 contracts with the entities providing comprehensive inpatient
135 and outpatient mental health care services to Medicaid
136 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
137 Counties, to include substance abuse treatment services.

138 2. By July 1, 2003, the agency and the department ~~of~~
139 ~~Children and Family Services~~ shall execute a written agreement
140 that requires collaboration and joint development of all policy,

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141 budgets, procurement documents, contracts, and monitoring plans
142 that have an impact on the state and Medicaid community mental
143 health and targeted case management programs.

144 3. Except as provided in subparagraph 8., by July 1, 2006,
145 the agency and the department ~~of Children and Family Services~~
146 shall contract with managed care entities in each AHCA area
147 except area 6 or arrange to provide comprehensive inpatient and
148 outpatient mental health and substance abuse services through
149 capitated prepaid arrangements to all Medicaid recipients who
150 are eligible to participate in such plans under federal law and
151 regulation. In AHCA areas where eligible individuals number
152 fewer ~~less~~ than 150,000, the agency shall contract with a single
153 managed care plan to provide comprehensive behavioral health
154 services to all recipients who are not enrolled in a Medicaid
155 health maintenance organization or a Medicaid capitated managed
156 care plan authorized under s. 409.91211. The agency may contract
157 with more than one comprehensive behavioral health provider to
158 provide care to recipients who are not enrolled in a Medicaid
159 capitated managed care plan authorized under s. 409.91211 or a
160 Medicaid health maintenance organization in AHCA areas where the
161 eligible population exceeds 150,000. In an AHCA area where the
162 Medicaid managed care pilot program is authorized pursuant to s.
163 409.91211 in one or more counties, the agency may procure a
164 contract with a single entity to serve the remaining counties as
165 an AHCA area or the remaining counties may be included with an
166 adjacent AHCA area and are ~~shall be~~ subject to this paragraph.
167 Contracts for comprehensive behavioral health providers awarded
168 pursuant to this section must ~~shall~~ be competitively procured.

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169 Both for-profit and not-for-profit corporations are eligible to
170 compete. Managed care plans contracting with the agency under
171 subsection (3) must ~~shall~~ provide and receive payment for the
172 same comprehensive behavioral health benefits as provided in
173 AHCA rules, including handbooks incorporated by reference. In
174 AHCA area 11, the agency shall contract with at least two
175 comprehensive behavioral health care providers to provide
176 behavioral health care to recipients in that area who are
177 enrolled in, or assigned to, the MediPass program. One of the
178 behavioral health care contracts must be with the existing
179 provider service network pilot project, as described in
180 paragraph (d), for the purpose of demonstrating the cost-
181 effectiveness of providing ~~the provision of~~ quality mental
182 health services through a public hospital-operated managed care
183 model. Payment shall be at an agreed-upon capitated rate to
184 ensure cost savings. Of the recipients in area 11 who are
185 assigned to MediPass under s. 409.9122(2)(k), a minimum of
186 50,000 of those MediPass-enrolled recipients shall be assigned
187 to the existing provider service network in area 11 for their
188 behavioral care.

189 4. By October 1, 2003, the agency and the department shall
190 submit a plan to the Governor, the President of the Senate, and
191 the Speaker of the House of Representatives which provides for
192 the full implementation of capitated prepaid behavioral health
193 care in all areas of the state.

194 a. Implementation shall begin in 2003 in those AHCA areas
195 of the state where the agency is able to establish sufficient
196 capitation rates.

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197 b. If the agency determines that the proposed capitation
198 rate in any area is insufficient to provide appropriate
199 services, the agency may adjust the ~~capitation~~ rate to ensure
200 that care is ~~will be~~ available. The agency and the department
201 may use existing general revenue to address any additional
202 required match but may not over-obligate existing funds on an
203 annualized basis.

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

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

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

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225 7. Traditional community mental health providers under
226 contract with the department ~~of Children and Family Services~~
227 pursuant to part IV of chapter 394, child welfare providers
228 under contract with the department ~~of Children and Family~~
229 ~~Services~~ in areas 1 and 6, and inpatient mental health providers
230 licensed pursuant to chapter 395 must be offered an opportunity
231 to accept or decline a contract to participate in any provider
232 network for prepaid behavioral health services.

233 8. All Medicaid-eligible children, except children in area
234 1 and children in Highlands County, Hardee County, Polk County,
235 or Manatee County of area 6, that are open for child welfare
236 services in the HomeSafeNet system, shall receive their
237 behavioral health care services through a specialty prepaid plan
238 operated by community-based lead agencies through a single
239 agency or formal agreements among several agencies. The
240 specialty prepaid plan must result in savings to the state
241 comparable to savings achieved in other Medicaid managed care
242 and prepaid programs. Such plan must provide mechanisms to
243 maximize state and local revenues. The specialty prepaid plan
244 shall be developed by the agency and the department ~~of Children~~
245 ~~and Family Services~~. The agency may seek federal waivers to
246 implement this initiative. Medicaid-eligible children whose
247 cases are open for child welfare services in the HomeSafeNet
248 system and who reside in AHCA area 10 are exempt from the
249 specialty prepaid plan upon the development of a service
250 delivery mechanism for children who reside in area 10 as
251 specified in s. 409.91211(3)(dd).

252 9. To ensure unimpaired access to behavioral health care

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253 services by Medicaid recipients, all contracts issued pursuant
254 to this paragraph must require that 80 percent of the capitation
255 paid to the managed care plan, including health maintenance
256 organizations, be expended for the provision of behavioral
257 health care services. If the plan expends less than 80 percent,
258 the difference must be returned to the agency and deposited into
259 the Medical Care Trust Fund. The agency shall maintain a
260 separate accounting of repayments deposited into the trust fund.
261 Repayments, minus federal matching funds that must be returned
262 to the Federal Government, shall be allocated to community
263 behavioral health providers enrolled in the networks of the
264 managed care plans that made the repayments. Funds shall be
265 allocated in proportion to each community behavioral health
266 agency's earnings from the managed care plan making the
267 repayment. Providers shall use the funds for any Medicaid-
268 allowable type of community behavioral health and case
269 management service. Community behavioral health agencies shall
270 be reimbursed by the agency on a fee-for-service basis for
271 allowable services up to their redistribution amount as
272 determined by the agency. Reinvestment amounts must be
273 calculated annually within 60 days after the managed care plan
274 files its annual 80 percent spending report.

275 Section 2. This act shall take effect July 1, 2010.