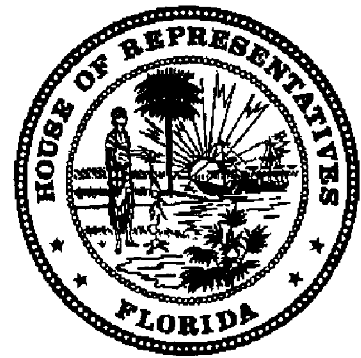

State Budget Conference Chairs

Bump Issues
Senate Offer # 3

<u>Conforming Language</u>
SB 1484 – Medicaid

Thursday, April 29, 2010, ~~8:30~~ pm
212 Knott Building
Webster Hall

Postponed until 9:00 pm

Health Care Appropriations – Health and Human Services Appropriations
Fiscal Year 2010-2011

Senate Offer #3
CS/CS/Senate Bill 1484, First Engrossed, relating to Health and Human Services Appropriations

House/Senate Concur – Closed Provisions
Replace all existing language with the following provisions:

- Directs the Agency for Health Care Administration (AHCA) to request an extension of the current Medicaid Reform waiver obtained under section 1115 of the Social Security Act and to preserve the Low Income Pool provisions of the waiver. The AHCA is required to provide the Legislature and the Governor with monthly progress on the waiver extension negotiations.

- Directs the AHCA to develop methodologies to integrate the use of intergovernmental transfers and certified public expenditures into the payment methodology for capitated Medicaid managed care plans. Requires the Secretary of the AHCA to convene a workgroup of stakeholders. The workgroup shall include individuals representing hospitals, counties, medical schools, managed care plans, and Medicaid provider-service-networks.

- Incorporate the provisions of CS/CS Senate Bill 8, First Engrossed, relating to Medicaid and Public Assistance Fraud

Senate offers the following additional provisions:

1. Revises the requirements for the selection of a behavioral health care provider in Broward County for children who have a case open in the Department of Children and Family Services's HomeSafeNet (HSN, Florida's child welfare reporting system), to allow those children who are in the custody of the State to enroll in a managed care plan which provides both physical and mental health care services. Authorizes a participating specialty plan to receive an administrative fee for coordination of services based upon the receipt of the state share of the fee from intergovernmental transfers.

2. Allows a provider service network to provide behavioral health services in addition to physical health services in areas of the state not under Medicaid reform.

3. Extends the guidelines for phasing in financial risk for approved provider service networks and Children's Medical Services Networks over the period of the waiver and the extension thereof.

1

s.409.91211(3)(dd), F.S. is amended to Read

958 ~~developmental disabilities sufficient to meet the medical,~~
959 ~~developmental, and emotional needs of these persons.~~
960 (dd) To implement service delivery mechanisms within a
961 specialty plan in area 10 ~~capitated managed care plans~~ to
962 provide behavioral health care services ~~Medicaid services as~~
963 ~~specified in ss. 409.905 and 409.906~~ to Medicaid-eligible
964 children whose cases are open for child welfare services in the
965 HomeSafeNet system. These services must be coordinated with
966 community-based care providers as specified in s. 409.1671,
967 where available, and be sufficient to meet the ~~medical,~~
968 developmental, behavioral, and emotional needs of these
969 children. Children in area 10 who have an open case in the
970 HomeSafeNet system shall be enrolled into the specialty plan.
971 These service delivery mechanisms must be implemented no later
972 than July 1, 2011 ~~2008~~, in AHCA area 10 in order for the
973 children in AHCA area 10 to remain exempt from the statewide
974 plan under s. 409.912(4)(b)8. An administrative fee may be paid
975 to the specialty plan for the coordination of services based on
976 the receipt of the state share of that fee being provided
977 through intergovernmental transfers.

2

146 and investigative agencies in detecting and deterring this type
147 of fraudulent activity, NOW, THEREFORE,
148
149 Be It Enacted by the Legislature of the State of Florida:
150
151 Section 1. Paragraph (b) of subsection (4) of section
152 409.912, Florida Statutes, is amended, ~~paragraph (d) of~~
153 ~~subsection (4) of that section is reenacted, present subsections~~
154 ~~(23) through (53) of that section are renumbered as subsections~~
155 ~~(24) through (54), respectively, a new subsection (23) is added~~
156 ~~to that section, and present subsections (21) and (22) of that~~
157 ~~section are amended, to read~~:
158 409.912 Cost-effective purchasing of health care.—The
159 agency shall purchase goods and services for Medicaid recipients
160 in the most cost-effective manner consistent with the delivery
161 of quality medical care. To ensure that medical services are
162 effectively utilized, the agency may, in any case, require a
163 confirmation or second physician's opinion of the correct
164 diagnosis for purposes of authorizing future services under the
165 Medicaid program. This section does not restrict access to
166 emergency services or poststabilization care services as defined
167 in 42 C.F.R. part 438.114. Such confirmation or second opinion
168 shall be rendered in a manner approved by the agency. The agency
169 shall maximize the use of prepaid per capita and prepaid
170 aggregate fixed-sum basis services when appropriate and other
171 alternative service delivery and reimbursement methodologies,
172 including competitive bidding pursuant to s. 287.057, designed
173 to facilitate the cost-effective purchase of a case-managed
174 continuum of care. The agency shall also require providers to

175 minimize the exposure of recipients to the need for acute
176 inpatient, custodial, and other institutional care and the
177 inappropriate or unnecessary use of high-cost services. The
178 agency shall contract with a vendor to monitor and evaluate the
179 clinical practice patterns of providers in order to identify
180 trends that are outside the normal practice patterns of a
181 provider's professional peers or the national guidelines of a
182 provider's professional association. The vendor must be able to
183 provide information and counseling to a provider whose practice
184 patterns are outside the norms, in consultation with the agency,
185 to improve patient care and reduce inappropriate utilization.
186 The agency may mandate prior authorization, drug therapy
187 management, or disease management participation for certain
188 populations of Medicaid beneficiaries, certain drug classes, or
189 particular drugs to prevent fraud, abuse, overuse, and possible
190 dangerous drug interactions. The Pharmaceutical and Therapeutics
191 Committee shall make recommendations to the agency on drugs for
192 which prior authorization is required. The agency shall inform
193 the Pharmaceutical and Therapeutics Committee of its decisions
194 regarding drugs subject to prior authorization. The agency is
195 authorized to limit the entities it contracts with or enrolls as
196 Medicaid providers by developing a provider network through
197 provider credentialing. The agency may competitively bid single-
198 source-provider contracts if procurement of goods or services
199 results in demonstrated cost savings to the state without
200 limiting access to care. The agency may limit its network based
201 on the assessment of beneficiary access to care, provider
202 availability, provider quality standards, time and distance
203 standards for access to care, the cultural competence of the

204 provider network, demographic characteristics of Medicaid
205 beneficiaries, practice and provider-to-beneficiary standards,
206 appointment wait times, beneficiary use of services, provider
207 turnover, provider profiling, provider licensure history,
208 previous program integrity investigations and findings, peer
209 review, provider Medicaid policy and billing compliance records,
210 clinical and medical record audits, and other factors. Providers
211 shall not be entitled to enrollment in the Medicaid provider
212 network. The agency shall determine instances in which allowing
213 Medicaid beneficiaries to purchase durable medical equipment and
214 other goods is less expensive to the Medicaid program than long-
215 term rental of the equipment or goods. The agency may establish
216 rules to facilitate purchases in lieu of long-term rentals in
217 order to protect against fraud and abuse in the Medicaid program
218 as defined in s. 409.913. The agency may seek federal waivers
219 necessary to administer these policies.
220 (4) The agency may contract with:
221 (b) An entity that is providing comprehensive behavioral
222 health care services to certain Medicaid recipients through a
223 capitated, prepaid arrangement pursuant to the federal waiver
224 provided for by s. 409.905(5). Such entity must be licensed
225 under chapter 624, chapter 636, or chapter 641, or authorized
226 under paragraph (c) <u>or paragraph (d)</u>, and must possess the
227 clinical systems and operational competence to manage risk and
228 provide comprehensive behavioral health care to Medicaid
229 recipients. As used in this paragraph, the term "comprehensive
230 behavioral health care services" means covered mental health and
231 substance abuse treatment services that are available to
232 Medicaid recipients. The secretary of the Department of Children

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

233 and Family Services shall approve provisions of procurements
234 related to children in the department's care or custody before
235 enrolling such children in a prepaid behavioral health plan. Any
236 contract awarded under this paragraph must be competitively
237 procured. In developing the behavioral health care prepaid plan
238 procurement document, the agency shall ensure that the
239 procurement document requires the contractor to develop and
240 implement a plan to ensure compliance with s. 394.4574 related
241 to services provided to residents of licensed assisted living
242 facilities that hold a limited mental health license. Except as
243 provided in subparagraph 8., and except in counties where the
244 Medicaid managed care pilot program is authorized pursuant to s.
245 409.91211, the agency shall seek federal approval to contract
246 with a single entity meeting these requirements to provide
247 comprehensive behavioral health care services to all Medicaid
248 recipients not enrolled in a Medicaid managed care plan
249 authorized under s. 409.91211, a provider service network
250 authorized under paragraph (d), or a Medicaid health maintenance
251 organization in an AHCA area. In an AHCA area where the Medicaid
252 managed care pilot program is authorized pursuant to s.
253 409.91211 in one or more counties, the agency may procure a
254 contract with a single entity to serve the remaining counties as
255 an AHCA area or the remaining counties may be included with an
256 adjacent AHCA area and are subject to this paragraph. Each
257 entity must offer a sufficient choice of providers in its
258 network to ensure recipient access to care and the opportunity
259 to select a provider with whom they are satisfied. The network
260 shall include all public mental health hospitals. To ensure
261 unimpaired access to behavioral health care services by Medicaid

262 recipients, all contracts issued pursuant to this paragraph must
263 require 80 percent of the capitation paid to the managed care
264 plan, including health maintenance organizations <u>and capitated</u>
265 <u>provider service networks</u>, to be expended for the provision of
266 behavioral health care services. If the managed care plan
267 expends less than 80 percent of the capitation paid for the
268 provision of behavioral health care services, the difference
269 shall be returned to the agency. The agency shall provide the
270 plan with a certification letter indicating the amount of
271 capitation paid during each calendar year for behavioral health
272 care services pursuant to this section. The agency may reimburse
273 for substance abuse treatment services on a fee-for-service
274 basis until the agency finds that adequate funds are available
275 for capitated, prepaid arrangements.
276 1. By January 1, 2001, the agency shall modify the
277 contracts with the entities providing comprehensive inpatient
278 and outpatient mental health care services to Medicaid
279 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
280 Counties, to include substance abuse treatment services.
281 2. By July 1, 2003, the agency and the Department of
282 Children and Family Services shall execute a written agreement
283 that requires collaboration and joint development of all policy,
284 budgets, procurement documents, contracts, and monitoring plans
285 that have an impact on the state and Medicaid community mental
286 health and targeted case management programs.
287 3. Except as provided in subparagraph 8., by July 1, 2006,
288 the agency and the Department of Children and Family Services
289 shall contract with managed care entities in each AHCA area
290 except area 6 or arrange to provide comprehensive inpatient and

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291 outpatient mental health and substance abuse services through
292 capitated prepaid arrangements to all Medicaid recipients who
293 are eligible to participate in such plans under federal law and
294 regulation. In AHCA areas where eligible individuals number less
295 than 150,000, the agency shall contract with a single managed
296 care plan to provide comprehensive behavioral health services to
297 all recipients who are not enrolled in a Medicaid health
298 maintenance organization, a provider service network authorized
299 under paragraph (d), or a Medicaid capitated managed care plan
300 authorized under s. 409.91211. The agency may contract with more
301 than one comprehensive behavioral health provider to provide
302 care to recipients who are not enrolled in a Medicaid capitated
303 managed care plan authorized under s. 409.91211, a provider
304 service network authorized under paragraph (d), or a Medicaid
305 health maintenance organization in AHCA areas where the eligible
306 population exceeds 150,000. In an AHCA area where the Medicaid
307 managed care pilot program is authorized pursuant to s.
308 409.91211 in one or more counties, the agency may procure a
309 contract with a single entity to serve the remaining counties as
310 an AHCA area or the remaining counties may be included with an
311 adjacent AHCA area and shall be subject to this paragraph.
312 Contracts for comprehensive behavioral health providers awarded
313 pursuant to this section shall be competitively procured. Both
314 for-profit and not-for-profit corporations are eligible to
315 compete. Managed care plans contracting with the agency under
316 subsection (3) or paragraph (d), shall provide and receive
317 payment for the same comprehensive behavioral health benefits as
318 provided in AHCA rules, including handbooks incorporated by
319 reference.

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Section ------: Paragraph (e) of subsection (3) of Section 409.91211, Florida Statutes is amended to read:

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks that, for purposes of this paragraph, include the Children's Medical Services Network, over a the ~~5-year~~ period of the waiver and the extension thereof. These policies and guidelines must include an option to be paid fee-for-service rates. For any provider service network establish in a managed care pilot area, the option to be paid fee-for-service rates must include a savings-settlement mechanism that is consistent with s. 409.912(44). This model must be converted to a risk-adjusted capitated rate by the beginning of the final~~sixth~~ year of operation under the waiver extension, and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.