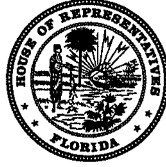
Committee on Health Innovation

Tuesday, March 11, 2008
8:00 AM - 9:30 AM
212 Knott Building

Marco Rubio
Speaker

Rene Garcia
Chair



House of Representatives

Committee on Health Innovation

AGENDA

March 11, 2008
8:00 AM - 9:30 AM
212 Knott Building

I. Opening Remarks by Chair Garcia

II. Introduction of Secretary Holly Benson, Agency for Health Care Administration

III. Consideration of the following bills:

HB 525 – Medical Assistance Eligibility of Inmates by Rep. Roberson

HB 691 – Medicaid Recipients with Psychiatric Disabilities by Rep. Zapata

IV. Workshop on Medicaid Durable Medical Equipment Fraud

V. Closing Remarks by Chair Garcia

VI. Adjournment

214 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300 (850) 487-2242

HB 525

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 525 Medical Assistance Eligibility of Inmates
SPONSOR(S): Roberson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1456

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation		Quinn-Gato	Calamas
2) Healthcare Council			
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

HB 525 requires Medicaid eligibility to be suspended for any individual who is an inmate in the state's correctional system or a county or municipal facility, and who was eligible for and received Medicaid benefits under chapter 409 immediately prior to being incarcerated. The bill clarifies that Medicaid benefits may not be used to pay for medical care, services, or supplies provided during the inmate's incarceration, and provides that nothing prevents the inmate from receiving inpatient hospital services outside the premises of the correctional institution to the extent that federal financial participation is available for the cost of such services.

The bill further provides that upon release from incarceration, an individual shall continue to be eligible for Medicaid benefits until such time as the person is determined to no longer be eligible.

Finally, the bill requires that, to the extent permitted under federal law, the time period for calculating when the inmate's eligibility must be recertified shall be stayed during the time the inmate is incarcerated.

The bill has an indeterminate negative fiscal impact on the Medicaid program, and requires an appropriation of $364,005 in fiscal year 2008-2009 and $271,764 in fiscal year 2009-2010 of General Revenue funds by the Department of Children and Families for staffing and equipment changes. (see Fiscal Impact and Comments sections).

The effective date of the bill is July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited government-The bill will require an increase in the number of full time equivalent employees at the Department of Children and Families in order to employ 6 Economic Self-Sufficiency experts, one for each region, in order to implement and maintain the changes required in the bill.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid Eligibility Determinations

Medicaid eligibility for Floridians is determined through the Social Security Administration ("SSA") for individuals who qualify for Social Security Income ("SSI") benefits[1], or by the Department of Children and Families ("DCF") for individuals who meet the income level and other requirements for programs for children and families or institutional care.[2]

When Floridians qualify for Medicaid through the Department of Children and Families ("DCF"), their application and enrollment information is maintained on the FLORIDA system at the Department of Children and Families and then transmitted to the Florida Medicaid Management Information System ("FMMIS") administered by the Agency for Health Care Administration ("AHCA").[3] Information for Floridians receiving SSI benefits through the SSA is maintained and updated by the SSA and transferred to the FMMIS, where provider billing and service provision is handled.[4]

Pursuant to section 1634 of the Social Security Act, Florida's Medicaid program has agreed to accept eligibility determinations made by the SSA for the provision of Medicaid coverage.[5] If an individual's eligibility is terminated by the SSA, then Medicaid cannot provide or suspend coverage for that individual unless he or she qualifies for eligibility through DCF.[6]

Federal law requires that states re-determine each Medicaid recipient's eligibility every 12 months, and must have procedures in place for recipients to notify Medicaid of changes in circumstance that may affect their eligibility.[7] If a recipient is blind or disabled, however, the recipients' disability is considered "continuing" until a medical evaluation determines that the recipient is no longer eligible for Medicaid.[8]

Federal Law Concerning the Use of Medicaid Funds for Incarcerated Individuals

---

[1] Individuals who receive SSI cash benefits are automatically eligible for Medicaid. *See* DCF website concerning general information about Medicaid, located on March 8, 2008 at http://www.dcf.state.fl.us/ess/medicaid.shtml; 42 C.F.R. s. 435.120.
[2] s. 409.902, F.S.
[3] *See* Agency for Health Care Administration 2008 Bill Analysis And Economic Impact Statement for HB 525; Department Of Children And Families Staff Analysis And Economic Impact Statement for HB 525.
[4] *Id.*
[5] 42 U.S.C. s. 1383c (this is accomplished through an agreement between the State and the Commissioner of Social Security).
[6] *Id; See also* Agency for Health Care Administration 2008 Bill Analysis And Economic Impact Statement for HB 525.
[7] 42 C.F.R. s. 435.916.
[8] Id.

Federal law precludes the use of Medicaid funds for health care or services provided to inmates of public institutions.[9] A "public institution" is a facility that is administered by a governmental unit or over which a governmental unit has administrative control.[10] Municipal, county and state jails and prisons are public institutions. Federal law allows exceptions for services to incarcerated Medicaid recipients by certain provider entities, including inpatient care at a medical institution, and does not prohibit the use of federal funds for such care.[11] A "medical institution" is a facility licensed under state law that provides medical, nursing, and convalescent care by licensed health care professionals.[12] Hospitals, for example, are medical institutions.

Federal law permits states to suspend or terminate an inmate's Medicaid eligibility. On May 25, 2004, the Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, issued a Memorandum to State Medicaid Directors and CMS Association Regional Administrators for Medicaid regarding chronic homelessness.[13] In that Memorandum, CMS reiterated that payment exclusions for incarcerated individuals under Medicaid do not affect the eligibility of those individuals, and encouraged states to adopt a policy of suspending, rather than terminating, an individual's Medicaid eligibility upon incarceration.[14]

Florida Practices Regarding Incarcerated Medicaid Recipients

Currently, when DCF is notified that an individual who receives Medicaid through the DCF eligibility process is incarcerated, DCF terminates that individual's enrollment in Medicaid at the end of the month and the individual must re-apply for Medicaid benefits upon release.[15] Similarly, when the SSA is notified that an individual receiving SSI benefits is incarcerated, the SSA transmits a termination code the FFMIS, which signals termination due to incarceration.[16] Thus, the incarcerated individual must re-apply for SSI benefits upon release.[17]

Pursuant to the Social Security Act, the SSA enters into agreements with state or local jails, prisons, penal institutions, or correctional facilities to provide payments each time the state or local entity notifies the SSA of an incarcerated individual who received SSI benefits the month immediately preceding incarceration.[18] Subject to certain reductions or limitations, the payment is $400 if the entity provides the information to the SSA within 30 days of the individual's confinement, or $200 if the institution provides the information between 30 and 90 days after the individual's confinement.[19]

For individuals that apply and are eligible for Medicaid benefits through the Department of Children of Families, DCF and AHCA have indicated that the FLORIDA and FMMIS systems are not currently programmed to include months of "partial eligibility."[20] Accordingly, the systems are not currently able to suspend Medicaid eligibility in what is called an "incarceration span" once the individual is incarcerated.[21]

---

[9] 42 U.S.C. s. 1396d(a)(28)(A).
[10] 42 C.F.R. s. 435.1010.
[11] 42 U.S.C. s. 1396d(a)(28)(A)
[12] 42 C.F.R. s. 435.1010.
[13] *See* May 25, 2004 Letter from Charlene Brown, Acting Director, Disabled and Elderly Health Programs Group to State Medicaid Directors and CMS Associate Regional Administrators for Medicaid; located on February 29, 2008 at http://www.cms.hhs.gov/HomelessnessInitiative/Downloads/SMDLetter.pdf.
[14] *Id.*
[15] See Department Of Children And Families Staff Analysis And Economic Impact Statement for HB 525.
[16] *See* Agency for Health Care Administration 2008 Bill Analysis And Economic Impact Statement for HB 525. SSI benefits are suspended if an individual is incarcerated for less than one year; however, if incarceration is for more than one year, then SSI benefits are terminated and the individual must reapply upon release. *See* 20 CF.R. s. 416.1335.
[17] *See* 20 CF.R. s. 416.1335.
[18] 42 U.S.C. s. 1382(e)(1)(I); 42 U.S.C. s. 402(x)(1)(A).
[19] *Id.*
[20] See *supra* note 4.
[21] *Id.*

Furthermore, as set forth above, pursuant to the Medicaid program's agreement with the Social Security Administration, Medicaid eligibility cannot be suspended for incarcerated individuals who qualify for SSI if the SSA terminates a recipient's eligibility.

Effect of Proposed Changes

HB 525 creates s. 409.9025, F.S., and requires that Medicaid eligibility be suspended for any individual who is an inmate in the state's correctional system, or a county or municipal facility, and who was eligible for and received Medicaid benefits under chapter 409 immediately prior to being incarcerated. The bill provides that Medicaid benefits may not be used to pay for medical care, services, or supplies provided during the inmate's incarceration, which is consistent with federal law. The bill clarifies that nothing in s. 409.9025, F.S. prevents the inmate from receiving inpatient hospital services outside the premises of the correctional institution to the extent that federal financial participation is available for the cost of such services. Where Medicaid is notified of an incarcerated recipient, it does not reimburse for such services because eligibility is terminated upon notice.

The bill further provides that upon release from incarceration, an individual shall continue to be eligible for Medicaid benefits until such time as the person is determined to no longer be eligible for such benefits. Finally, the bill requires that, to the extent permitted under federal law, during the time of incarceration, the time period for calculating when the inmate's eligibility must be recertified shall be stayed.

The effective date of the bill is July 1, 2008.

C. SECTION DIRECTORY:

Section 1. Creates s. 409.9025, F.S., relating to an individual's eligibility for Medicaid while an inmate.

Section 2. Provides an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The proposed legislation will require FLORIDA System programming changes to support the process of suspending and reinstating benefits. DCF estimates it will require 985 hours for programming the necessary changes. DCF also estimates they will need six additional Economic Self-Sufficiency Specialists (one per region) to review exception reports and to timely suspend and reinstate benefits including Medicaid, cash assistance and food stamps. The positions have been lapsed 25% for the 2008-09 fiscal year, but will require full funding in the 2009-10 fiscal year. See fiscal comments for further information.

	2008-09	**2009-10**
DCF (6.0 FTE)	$240,798	$271,764
Contractual Services	$123,207	$ 0
Total Expenditures	$364,005*	$271,764

*Fiscal Year 2008-09 includes $149,535 in non-recurring funding for equipment for the new staff positions and non-recurring funding for the FLORIDA system changes.

General Revenue Fund	$364,005	$271,764

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   At present, when a state or local facility notifies the SSA that an individual receiving SSI benefits is incarcerated, then the facility receives a payment from the SSA. According to AHCA, it is unclear whether this payment would be impacted by the bill.[22]

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

AHCA will be working with the Florida Department of Law Enforcement (FDLE) to collect the names of those Medicaid beneficiaries moving in and out of incarceration and will be "suspending" coverage to prevent Medicaid benefits from being paid in error. DCF will be working with AHCA to ensure they have access to the incarceration data so the data can be reflected in the FLORIDA eligibility determination system. The FLORIDA system is used to determine eligibility for Medicaid, Food Stamps and cash assistance. The incarceration data obtained from AHCA will be used to ensure all program benefits are managed correctly. As these individuals move in and out of incarceration, DCF will ensure their Medicaid (and any Food Stamps and any cash assistance) benefits are correct.

Projections from AHCA indicate there are approximately 62,000 Medicaid eligible or potentially eligible individuals arrested each year. The Social Security Administration (SSA) creates Medicaid eligibility for those eligible for Supplemental Security Income (SSI) and the SSI beneficiaries make up approximately 50% of the incarcerated population. That leaves some 30,000 individuals who have their eligibility determined by DCF. DCF is requesting one FTE per Region for a total of six positions to implement this legislation. The staff would be specifically designated to work the cases reported by AHCA as individuals are moving in and/or out of county or local jail. One of the critical keys to the success of this bill will be timely action on the information received from AHCA. Given the potential volume of these case changes, dedicated positions will ensure this takes place. Mixing these changes with other program eligibility work could result in individuals receiving (or not receiving) their Medicaid benefits in error.

The bill allows for the provision of medical assistance for inpatient hospital services to be furnished to an inmate at a hospital outside of the premises of the inmate's facility to the extent that federal financial participation is available for the costs of such services. The bill would also prevent Medicaid beneficiaries from having a gap in medical coverage and would allow immediate access to Medicaid services upon release from incarceration. These provisions could potentially cause an indeterminate negative fiscal impact of Medicaid expenditures.

---

[22] *See* Agency for Health Care Administration 2008 Bill Analysis And Economic Impact Statement for HB 525.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

As set forth above, if this bill passes, it is unclear whether counties and municipalities will be able to continue to raise revenue in the aggregate in the form of payments from the SSA for notification of incarcerated individuals. Accordingly, the mandates provision in Article VII, section 18(a) of the state constitution may be implicated. At this time, it is indeterminate whether the mandates provision would be implicated and, if so, whether an exemption would apply because the potential fiscal impact on each county or municipality also cannot be determined at this time.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

At lines 28 through 33 of the bill, the bill provides that "nothing in this section shall be deemed as preventing the provision of medical assistance for inpatient hospital services furnished to an inmate…;" however, such services may already be provided to an inmate under current law. Because current practice results in the termination of Medicaid eligibility, however, Medicaid does not currently cover such services.

D. STATEMENT OF THE SPONSOR

No statement provided.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to medical assistance eligibility of
3 inmates; creating s. 409.9025, F.S.; providing for
4 suspension of medical assistance for certain incarcerated
5 persons while such persons are inmates; providing an
6 exception; providing for eligibility following release
7 from incarceration; providing that, to the extent
8 permitted under federal law, the time during which such
9 person is an inmate shall not be included in any
10 calculation of when the person must recertify his or her
11 eligibility; providing an effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Section 409.9025, Florida Statutes, is created
16 to read:
17 409.9025 Eligibility while inmate.--
18 (1) Notwithstanding any other provision of law other than
19 s. 409.9021, in the event that a person who is an inmate in the
20 state's correctional system as defined in s. 944.02, in a county
21 detention facility as defined in s. 951.23, or in a municipal
22 detention facility as defined in s. 951.23 was in receipt of
23 medical assistance under this chapter immediately prior to being
24 admitted as an inmate, such person shall remain eligible for
25 medical assistance while an inmate, except that no medical
26 assistance shall be furnished under this chapter for any care,
27 services, or supplies provided during such time as the person is
28 an inmate; however, nothing in this section shall be deemed as

29 preventing the provision of medical assistance for inpatient
30 hospital services furnished to an inmate at a hospital outside
31 of the premises of the inmate's facility to the extent that
32 federal financial participation is available for the costs of
33 such services.
34 (2) Upon release from incarceration, such person shall
35 continue to be eligible for receipt of medical assistance
36 furnished under this chapter until such time as the person is
37 otherwise determined to no longer be eligible for such
38 assistance.
39 (3) To the extent permitted by federal law, the time
40 during which such person is an inmate shall not be included in
41 any calculation of when the person must recertify his or her
42 eligibility for medical assistance in accordance with this
43 chapter.
44 Section 2. This act shall take effect July 1, 2008.

HB 691

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 691 Medicaid Recipients with Psychiatric Disabilities

SPONSOR(S): Zapata and others

TIED BILLS: **IDEN./SIM. BILLS:** SB 846

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation		Quinn-Gato	Calamas
2) Healthcare Council			
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

HB 691 authorizes the Agency for Health Care Administration to contract with specialty provider service networks ("PSNs") that exclusively enroll Medicaid recipients with psychiatric disabilities. Further, the bill requires that, should the Medicaid recipient fail to select a managed care plan, the agency assign a Medicaid recipient with psychiatric disabilities to such specialty PSNs if a specialty PSN is available in the geographic area in which the recipient resides.

Similarly, in Medicaid reform pilot program areas, the bill requires the agency to contract with specialty PSNs specializing in psychiatric care, develop a definition of psychiatric disabilities in order to assign recipients to specialty PSNs, and develop a process for assigning recipients to such specialty PSNs when recipients fail to choose a managed care plan. Additionally, the bill requires the agency to take into account the existence of a recipient's known diagnoses or disabilities, including psychiatric disabilities, when assigning recipients who have not enrolled in a managed care plan within 30 days after eligibility is determined to managed care plans determined by the agency.

The fiscal impact on the Medicaid program is indeterminate, but the agency likely will require additional resources to implement (see Fiscal Comment section).

The bill is effective on July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Empower families-The bill benefits individuals and families by providing greater opportunity for specialized health care for individuals suffering from psychiatric disabilities.

Safeguard individual liberty-The bill increases health care options for Medicaid recipients with psychiatric disabilities.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid Managed Care

The Florida Medicaid Program pays for services in three ways: fee-for-service reimbursement to health care providers with direct contract relationships with the Medicaid program[1]; capitated fee payment to certain managed care organizations (Health Maintenance Organizations) which create provider networks by contract with health care providers and which bear full risk for the care of Medicaid recipients who enroll in the managed care organization; and fee-for-service reimbursement to certain managed care organizations (Provider Service Networks) which create provider networks by contract with health care providers and which must share any savings with the Medicaid program or pay Medicaid for lack of savings.

Medicaid uses a capitated payment model for Health Maintenance Organizations (HMOs), Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s. The HMOs are the provider type that account for the largest number of enrollees.

Rates for HMOs are set using basic risk adjustment factors (age, sex, geographic location and eligibility group), but are not established by assessing recipients' clinical risk. Within certain limits, Medicaid enrollees can choose to receive care in either a managed care or fee-for-service setting.[2] However, recipients who do not make a choice are automatically enrolled in either managed care plans or fee-for-service Medicaid disproportionately to reach a ratio of 65 percent and 35 percent, respectively.[3]

Medicaid uses fee-for-service reimbursement for Provider Service Networks (PSNs) such as minority physician networks. PSNs also receive a per-patient case management fee. Provider service networks are required by contract to demonstrate savings over historic fee-for-service care, and savings achieved above a set goal are shared with the PSN.[4] Historically, the contracts have provided that failure to achieve savings goals will result in reimbursement to Medicaid of a portion of the case management payments. While all minority physician networks have achieved savings to the Medicaid program, some networks have not met the savings goals set in their contracts.

---

[1] Also known as MediPass, the fee-for-service side of Medicaid involves primary case management by the agency.

[2] See s. 409.9122(2)(a), F.S.

[3] See s. 409.9122(2)(f),(k), F.S.

[4] Section 409.912(49), F.S.

Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized the Agency for Health Care Administration (AHCA) to seek and implement a federal waiver for a managed care pilot program.[5] AHCA received approval for the five-year pilot and began implementing reformed Medicaid in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007, pursuant to statutory direction. Current law sets a goal of statewide expansion by 2011.

The pilot program administers all health care services through managed care organizations, reimbursed using actuarially based, risk-adjusted, capitated rates. Reform allowed AHCA to open competition in the delivery of health care benefits by establishing a certification process, which permits a broad array of entities to become managed care plans upon meeting certain financial, programmatic, and administrative requirements.

In reform, risk-adjusted rates are achieved by considering the four factors used for non-reform HMOs (age, sex, geographic location and eligibility group), and an additional factor: clinical history. Recipients' clinical risk is scored based on a combination of historic drug claims and historic diagnosis information gleaned from encounter data submitted to AHCA by the health plans.[6] Without clinical risk adjustment, managed care organization payments might not reflect the level of risk they actually assume, and any one managed care plan may be overpaid or underpaid depending on the health status of the recipients who choose to enroll in that plan. This kind of risk adjustment creates disincentives for managed care plans to market to healthier recipients or to promote disenrollment by sicker individuals, often called "cherry picking." Rather, it creates incentives for managed care plans that have sicker patients to identify them as early as possible and work to manage their care to avoid experiencing high costs. Similarly, clinical risk adjustment creates opportunity for innovative managed care organizations to create plans that specialize in meeting the needs of high-risk patient groups.

Upon enrollment in Medicaid, recipients in reform counties have 30 days to voluntarily select a managed care plan. For those who do not make a choice, current law requires AHCA to assign the recipient to a plan "based on the assessed needs of the recipient as determined by the agency." In making such assignments, the agency must take into account several factors: the plan's network capacity; a prior relationship between the recipient and the plan or one of the plan's primary care providers; the recipient's preference for a particular network, as demonstrated by prior claims data; and geographic accessibility.[7]

Provider Service Networks

Provider Service Networks (PSNs) are organizations that are owned and operated by providers that deliver comprehensive health care to their enrolled population. By statute, providers in PSNs must have a controlling interest in the governing body of the PSN, and may make arrangements with physicians or other health care professionals, health institutions, or any combination thereof, to assume all or part of the financial risk on a prospective basis for the provision of basic health services by physicians, by other health professionals, or through the institutions.[8]

PSNs were introduced in the Florida Medicaid Program in 2002. In traditional Medicaid, PSNs use a fee-for-service payment system with payment limits and links between payments and quality of care through a series of performance indicators. In Medicaid reform counties, PSNs may be paid one of two

[5] Sections 409.91211 - 409.91213, F.S.

[6] The inclusion of clinical data in the risk adjustment is being phased in over three years. In addition, a statutory risk corridor preventing variance by more than 10 percent of the mean phases out in 2008. Ch. 409.91211(8), F.S.

[7] Section 409.91211(4)(a), F.S.

[8] Section 409.912(4)(d), F.S.

ways: PSNs may receive the capitated, risk-adjusted payment used by the HMOs; or, for the first three years and at the PSN's option, PSNs may be reimbursed on a fee-for-service basis which includes the savings reconciliation element required for non-reform areas.[9]

In non-Medicaid reform counties, PSNs provide comprehensive health care to enrollees; however, except for one PSN in Miami-Dade County, PSNs are not authorized to manage community behavioral health and targeted case management (see "Managed Behavioral Health Care in Florida" below).[10] Instead, when a PSN enrollee requires comprehensive behavioral health care[11], enrollees are referred by the PSN to a prepaid behavioral health plan for services.[12]

Under Medicaid reform, PSNs participate as managed care organizations in the pilot counties and compete with HMOs for recipient enrollment. PSNs may choose to be reimbursed on a fee-for-service basis or on a risk-adjusted capitated basis for the initial three years of the program, and then must convert to risk-adjusted capitated methodology used by HMOs in reform at the end of the third year of operation.[13]

In reform, AHCA is currently authorized to contract with specialty plans for certain populations,[14] and the fully risk-adjusted payment methodology of reformed Medicaid will establish the ability to adequately compensate and incentivize the development of these and other specialty PSNs. The 1115 Medicaid Reform Waiver approved by the Centers for Medicare and Medicaid Services mandates that the State review and approve specialty plans pursuant to criteria that includes the appropriateness of the target population and the existence of clinical programs or special expertise to serve that target population.[15]

Managed Behavioral Health Care in Florida

AHCA provides behavioral health services for Medicaid recipients statewide using capitated prepaid and managed care programs. Florida began testing managed care models for providing mental health care for Medicaid enrollees under a 1915(b) waiver, as a mental health carve-out demonstration project in 1996 in the Tampa Bay area. The purpose of the demonstration was to create a fully integrated mental health delivery system with financial and administrative mechanisms that support a shared clinical model.

Following the initial demonstration project, Florida has continued to expand managed care strategies to establish comprehensive mental health services for Medicaid beneficiaries. Initially these were reimbursed through a fee-for-service mechanism in which the state was at risk for mental health service utilization. For beneficiaries enrolled in the MediPass plan, both physical health and pharmacy benefits were paid for on a fee-for-service basis. For beneficiaries enrolled in a HMO, physical health and pharmacy benefits were paid for through a capitated arrangement.

State Plan services for mental health include:

- Inpatient psychiatric services.
- Outpatient hospital services for covered diagnosis.
- Community mental health services.
- Mental health targeted case management.

---

[9] Section 409.91211(3)(e), F.S.
[10] *See* s. 409.912(4)(b); Medicaid 2007-2008 Summary of Services, located at http://ahca.myflorida.com/Medicaid/pdffiles/SS_07_070701_SOS.pdf.
[11] "Comprehensive behavioral health care" refers to covered mental health and substance abuse treatment services. See s. 409.912(4)(b), F.S.
[12] See Agency for Health Care Administration 2008 Bill Analysis & Economic Impact Statement.
[13] Section 409.91211(3)(e), F.S.
[14] Section 409.91211(3)(bb) through (dd), F.S.
[15] Agency for Health Care Administration 2008 Bill Analysis and Economic Impact Statement.

• Psychiatrist physician services.

In 2005, with federal approval, Florida expanded managed care for mental health coverage under capitated Medicaid managed care plans throughout the state. Current law requires Medicaid to competitively procure a single prepaid behavioral health plan for each AHCA area, with a few exceptions.[16] AHCA has competitively procured a single prepaid behavioral health plan in each non-reform AHCA area. Those single plans currently exist in each AHCA area, with some exceptions and variances.[17]

Effect of Proposed Changes

Non-Reformed Medicaid

House Bill 691 authorizes AHCA to contract with specialty PSNs in non-reformed Medicaid that exclusively enroll Medicaid recipients with psychiatric disabilities. The bill modifies automatic assignment provisions for managed care recipients assigned to provider service networks, requiring AHCA to assign a Medicaid recipient with psychiatric disabilities who does not select a managed care plan within the specified time to such a specialty PSN should one be available in the geographic area in which the recipient resides.

It is unclear how the specialty PSNs will interact with the prepaid behavioral health plans currently under contract with AHCA. AHCA has interpreted the interaction between the bill and existing law to limit a specialty PSN to providing comprehensive health care, excluding behavioral healthcare, thereby requiring the specialty PSN to refer enrollees to a prepaid behavioral health plan for behavioral health services.[18]

Additionally, the term "psychiatric disability" for purposes of non-reform specialty PSNs is not defined in the bill.

Reformed Medicaid

The bill requires AHCA to seek applications for, and contract with, PSNs specializing in care for recipients with psychiatric disabilities in the reform pilot counties. Similar to provisions in current Medicaid reform law, the bill requires AHCA to establish assignment processes for such recipients who fail to choose a managed care plan. The bill does not expressly require such assignment, in apparent reliance on the provisions of current law requiring automatic assignment to plans based on the assessed needs of the recipient. The bill adds to the statutory criteria the agency must consider in making automatic assignments, requiring the agency to consider any known diagnoses or disabilities, including psychiatric disabilities. The bill requires AHCA develop a definition for the term "psychiatric disabilities" for purposes of reform specialty PSNs.

While current law requires the agency to assign recipients (who fail to make plan choices) to plans based on assessed needs, the bill refers to "known" diagnoses or disabilities. It is unclear whether "known" refers to Medicaid, or some other entity. If it is Medicaid's own knowledge about the recipient that is operative, this may negate any implication of a requirement for individualized clinical assessment in favor of an assessment based on (claims) information about the recipient already known to Medicaid. Under this interpretation, the use of the term "known" implies that new enrollees, with no Medicaid

[16] Section 409.912(4)(b), F.S.

[17] In AHCA Area 11, AHCA contracts with at least two comprehensive behavioral health care providers, one of which is a public hospital-operated PSN providing behavioral health services to a minimum of 50,000 MediPass recipients. Initially, in AHCA Area 6, the comprehensive behavioral health providers already under contract with AHCA were used and their contracts were later amended to include substance abuse treatment services. For children enrolled in Home SafeNet, comprehensive behavioral health services are provided through a specialty prepaid plan operated by a community based lead agency pursuant to s. 409.912(8), F.S.

[18] Agency for Health Care Administration 2008 Bill Analysis & Economic Impact Statement.

claims history, and current recipients without claims history indicating a psychiatric disability, would require no further assessment before assignment.

The effective date of the bill is July 1, 2008.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.912, F.S.; relating to cost-effective purchasing of health care.

Section 2. Amends s. 409.91211, F.S.; relating to Medicaid managed care pilot program.

Section 3. Providing an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate. See Fiscal Comments section.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   See fiscal comments below.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Some Medicaid recipients with behavioral health diagnoses are a high-risk. Specialty PSNs that develop in Medicaid reform counties as a result of this bill may need the targeted reimbursement that fully risk-adjusted rates without risk corridors can provide in order to meet the needs of their patients. Under current law, for most providers, risk corridors end in 2008, and full risk adjustment will be fully available in FY 2009-2010. However, specialty PSNs have the option to use full risk adjustment without risk corridors immediately.

D. FISCAL COMMENTS:

The bill would authorize AHCA to contract with a specialty PSN for recipients with psychiatric disabilities in non-reform areas, and require AHCA to contract with a specialty PSN for recipients with psychiatric disabilities in reform areas. AHCA has indicated that the fiscal impact cannot be determined at this time, and has raised the following issues:

- As no definition for psychiatric disability currently exists, it is unknown how many recipients may be eligible for enrollment in, and choose to enroll in or be assigned to, the specialty plan.
- For Medicaid reform areas, the next phase of expansion has not been determined by the Florida Legislature. Therefore, the number of recipients who may enroll in the specialty plan is not known.

- For non-reform areas, no proposals or applications for behavioral health specialty plans have been submitted to the agency, so it is unknown which counties would be covered by a specialty PSN and how many recipients might be enrolled. The number of children in the HomeSafeNet system who may meet the enrollment criteria for the specialty PSN will have to be assessed before the fiscal impact is known.

- The revisions to the assignment process may cause a delay in managed care enrollment processes such that additional fee-for-service expenditures may occur, which may be significant. The agency would need to develop a definition of psychiatric disabilities, an assessment tool and process in order to assess a recipient's psychiatric disability before assigning the recipient to a managed care plan Benefit plan administration and assignment plan rules will have to be added to ensure accurate selection of the potential assignment pool for the various health plans and to allow assignment for Medicaid beneficiaries that meet the plan enrollment criteria or the existence of any known diagnoses or disabilities. It is unclear which diagnoses or disabilities the agency would be required to take into account when making assignments into managed care plans. These additional assessment processes will require additional programming for the Medicaid enrollment and Choice Counseling vendors to incorporate into the Medicaid Reform auto-assignment process. Additional enrollment materials would need to be distributed to the recipients eligible to enroll in the specialty plan once the specialty plan becomes available. Therefore, additional resources would likely be needed.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not provide any rule making authority to the agency; however, the bill authorizes AHCA to develop and implement a definition of "psychiatric disabilities" and establish "assignment processes" for recipients with psychiatric disabilities who fail to choose a managed care plan in reform. AHCA has general rulemaking authority applicable to Medicaid reform provided for in s. 409.91211, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill at lines 91-92 references Medicaid recipients with "psychiatric disabilities." The term "psychiatric disabilities" is not defined; however, at lines 131-135, the bill authorizes AHCA to develop and implement a definition of "psychiatric disabilities" for purposes of the Medicaid reform pilot program. It is unclear what definition would apply to non-Medicaid reform areas.

According to AHCA, requiring AHCA to identify recipients with psychiatric disabilities in order to assign them to specialty PSNs would necessitate amendments to the Medicaid Reform Section 1115 Demonstration Waiver and the Section 1915(b) Managed Care Organization, Prepaid Inpatient Health Plan, Prepaid Ambulatory Health Plan, and Primary Care Case Management Waivers, which would require approval from CMS.[19] AHCA estimates that it could take four months to complete the waiver

---

[19] *Id.*

amendment process, which could delay the implementation of the bill.[20] It is unclear why an amendment would be required for the Medicaid Reform Section 1115 Demonstration Waiver. The current waiver does not specifically reference or preclude assignment by assessed needs. However, both the approved waiver application and the terms and conditions reference the auto-assignment criteria list as a minimum, authorizing additional (unnamed) criteria. In addition, assignment by needs assessment is required by current law.

AHCA anticipates that assignment of recipients with known diagnoses or disabilities could delay recipients' access to and enrollment into a health plan.[21] It is unclear why the bill should impact the 30-day plan choice period, as the bill's proposed automatic assignment to the non-reform specialty PSN is for recipients who fail to make a choice within the 30-day plan choice period. AHCA anticipates that for recipients in Medicaid reform areas, this delay could result in a beneficiary exceeding the statutory 30-day plan choice period, necessitating involuntary placement into a plan by Medicaid.[22] Again, it is unclear why the bill should impact the 30-day plan choice period, as the automatic assignment to the reform specialty PSN is for recipients who fail to make a choice within the 30-day plan choice period.

AHCA has also indicated that the provisions in lines 118-122 of the bill, which require a recipient with psychiatric disabilities being served in a non-Medicaid reform area be assigned to a specialty PSN if the recipient fails to select a managed care plan, and a specialty PSN is available in that geographic area, appear to conflict with s. 409.9122(k), F.S., which currently requires that recipients who fail to make a choice about managed care plans be assigned "equally" to MediPass or a managed care plan.[23] However, this language only applies to AHCA areas 1 and 6, not to all managed care assignments statewide. In addition, in SB 12C passed during Special Session C in 2007, the "equal" assignment language in s. 409.9122(k), F.S., was removed, thereby reverting those two AHCA areas to the statutory assignment scheme of assignment of all Medicaid recipients in non-reform areas who fail to choose a plan to be automatically enrolled in either managed care plans or fee-for-service Medicaid disproportionately to reach a ratio of 65 percent and 35 percent, respectively, pursuant to the remaining language in s. 409.9122(k), F.S. It is unclear how the mandatory assignment to a specialty PSN in the bill will interact with this assignment requirement.

Further, as discussed in the "Effect of Proposed Changes" section above, AHCA states that the bill does not indicate whether the specialty PSN will provide comprehensive health care.[24] In Medicaid reform areas, comprehensive health care includes behavioral health care for PSNs.[25] "In non-Medicaid reform counties, a specialty PSN will not be able to provide behavioral health care under existing law and will have to coordinate the behavioral health care with the competitively procured entities."[26]

D. STATEMENT OF THE SPONSOR

One of our greatest expectations from Medicaid reform, in addition to controlling future Medicaid expenditures, was to expand consumer choice of plans, increase competition among plans for Medicaid populations, develop programs that were customized for certain populations to promote better treatment outcomes, and improve plan accountability and value. We're still early in reform, but many of the plans are very much the same with the same benefit structures. With this bill, an entirely new choice would be available – a Specialty Provider Service Network for Medicaid beneficiaries with mental illness, a group accounting for the largest proportion of spending by disabled populations and a group that often has multiple co-morbid conditions and dies 20-25 years prematurely.

---

[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)
ADOPTED AS AMENDED __ (Y/N)
ADOPTED W/O OBJECTION __ (Y/N)
FAILED TO ADOPT __ (Y/N)
WITHDRAWN __ (Y/N)
OTHER ______

---

1 Council/Committee hearing bill: Health Innovation
2 Representative(s) Zapata offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Paragraph (d) 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
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
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.
70 (4) The agency may contract with:
71 (d) A provider service network, which may be reimbursed on
72 a fee-for-service or prepaid basis. A provider service network
73 that ~~which~~ is reimbursed by the agency on a prepaid basis is
74 ~~shall be~~ exempt from parts I and III of chapter 641, but must
75 comply with the solvency requirements in s. 641.2261(2) and meet
76 appropriate financial reserve, quality assurance, and patient
77 rights requirements as established by the agency.
78 1. Except as provided in subparagraph 2., Medicaid
79 recipients assigned to a provider service network shall be
80 chosen equally from those who would otherwise have been assigned
81 to prepaid plans and MediPass. The agency is authorized to seek
82 federal Medicaid waivers as necessary to implement the
83 provisions of this section. Any contract previously awarded to a
84 provider service network operated by a hospital pursuant to this

85 subsection shall remain in effect for a period of 3 years
86 following the current contract expiration date, regardless of
87 any contractual provisions to the contrary. A provider service
88 network is a network established or organized and operated by a
89 health care provider, or group of affiliated health care
90 providers, including minority physician networks and emergency
91 room diversion programs that meet the requirements of s.
92 409.91211, which provides a substantial proportion of the health
93 care items and services under a contract directly through the
94 provider or affiliated group of providers and may make
95 arrangements with physicians or other health care professionals,
96 health care institutions, or any combination of such individuals
97 or institutions to assume all or part of the financial risk on a
98 prospective basis for the provision of basic health services by
99 the physicians, by other health professionals, or through the
100 institutions. The health care providers must have a controlling
101 interest in the governing body of the provider service network
102 organization.
103 2. The agency shall seek applications for and is
104 authorized to contract with a specialty provider service network
105 that exclusively enrolls Medicaid beneficiaries who have
106 psychiatric disabilities. The Medicaid specialty provider
107 service network shall be responsible for providing the full
108 range of physical and behavioral health services that other
109 Medicaid health maintenance organizations and provider service
110 networks are required to provide. Medicaid beneficiaries having
111 psychiatric disabilities who are required but fail to select a
112 managed care plan shall be assigned to the specialty provider
113 service network in those geographic areas where a specialty
114 provider service network is available. For purposes of
115 enrollment, in addition to those who meet the diagnostic

116 criteria indicating a mental illness or emotional disturbance,
117 beneficiaries served by Medicaid-enrolled community mental
118 health agencies or who voluntarily choose the specialty provider
119 service network shall be presumed to meet the plan enrollment
120 criteria.
121 Section 2. Paragraphs (o) and (aa) of subsection (3) and
122 paragraphs (a), (b), (c), (d), and (e) of subsection (4) of
123 section 409.91211, Florida Statutes, are amended, and paragraph
124 (ee) is added to subsection (3) of that section, to read:
125 409.91211 Medicaid managed care pilot program.--
126 (3) The agency shall have the following powers, duties,
127 and responsibilities with respect to the pilot program:
128 (o) To implement eligibility assignment processes to
129 facilitate client choice while ensuring pilot programs of
130 adequate enrollment levels. These processes shall ensure that
131 pilot sites have sufficient levels of enrollment to conduct a
132 valid test of the managed care pilot program within a 2-year
133 timeframe. The eligibility assignment process shall be modified
134 as specified in paragraph (aa).
135 (aa) To implement a mechanism whereby Medicaid recipients
136 who are already enrolled in a managed care plan or the MediPass
137 program in the pilot areas shall be offered the opportunity to
138 change to capitated managed care plans on a staggered basis, as
139 defined by the agency. All Medicaid recipients shall have 30
140 days in which to make a choice of capitated managed care plans.
141 Those Medicaid recipients who do not make a choice shall be
142 assigned to a capitated managed care plan in accordance with
143 paragraph (4)(a) and shall be exempt from s. 409.9122. To
144 facilitate continuity of care for a Medicaid recipient who is
145 also a recipient of Supplemental Security Income (SSI), prior to
146 assigning the SSI recipient to a capitated managed care plan,

147 the agency shall determine whether the SSI recipient has an
148 ongoing relationship with a provider, including a community
149 mental health provider or capitated managed care plan, and, if
150 so, the agency shall assign the SSI recipient to that provider,
151 provider service network, or capitated managed care plan where
152 feasible. Those SSI recipients who do not have such a provider
153 relationship shall be assigned to a capitated managed care plan
154 provider in accordance with this paragraph and paragraphs (4)(a)
155 through (d) ~~and shall be exempt from s. 409.9122~~.
156 (ee) To develop and implement a service delivery
157 alternative within capitated managed care plans to provide
158 Medicaid services as specified in ss. 409.905 and 409.906 for
159 persons who have psychiatric disabilities which are sufficient
160 to meet the medical, developmental, and emotional needs of those
161 persons.
162 (4)(a) A Medicaid recipient in the pilot area who is not
163 currently enrolled in a capitated managed care plan upon
164 implementation is not eligible for services as specified in ss.
165 409.905 and 409.906, for the amount of time that the recipient
166 does not enroll in a capitated managed care network. If a
167 Medicaid recipient has not enrolled in a capitated managed care
168 plan within 30 days after eligibility, the agency shall assign
169 the Medicaid recipient to a capitated managed care plan based on
170 the assessed needs of the recipient as determined by the agency
171 and the recipient shall be exempt from s. 409.9122. When making
172 assignments, the agency shall take into account the following
173 criteria:
174 1. A capitated managed care network has sufficient network
175 capacity to meet the needs of members.
176 2. The capitated managed care network has previously
177 enrolled the recipient as a member, or one of the capitated

178 managed care network's primary care providers has previously
179 provided health care to the recipient.
180 3. The agency has knowledge that the member has previously
181 expressed a preference for a particular capitated managed care
182 network as indicated by Medicaid fee-for-service claims data,
183 but has failed to make a choice.
184 4. The capitated managed care network's primary care
185 providers are geographically accessible to the recipient's
186 residence.
187 5. The extent of the psychiatric disability of the
188 Medicaid beneficiary.
189 (b) When more than one capitated managed care network
190 provider meets the criteria specified in paragraph (3)(h), the
191 agency shall assess a beneficiary's psychiatric disability
192 before making an assignment and make recipient assignments
193 consecutively by family unit.
194 (c) If a recipient is currently enrolled with a Medicaid
195 managed care organization that also operates an approved reform
196 plan within a demonstration area and the recipient fails to
197 choose a plan during the reform enrollment process or during
198 redetermination of eligibility, the recipient shall be
199 automatically assigned by the agency into the most appropriate
200 reform plan operated by the recipient's current Medicaid managed
201 care plan. If the recipient's current managed care plan does not
202 operate a reform plan in the demonstration area which adequately
203 meets the needs of the Medicaid recipient, the agency shall use
204 the automatic assignment process as prescribed in the special
205 terms and conditions numbered 11-W-00206/4. All enrollment and
206 choice counseling materials provided by the agency must contain
207 an explanation of the provisions of this paragraph for current
208 managed care recipients and an explanation of the choice of any

209 specialty provider service network or specialty managed care
210 plan.
211 (d) Except as provided in paragraph (b), the agency may
212 not engage in practices that are designed to favor one capitated
213 managed care plan over another or that are designed to influence
214 Medicaid recipients to enroll in a particular capitated managed
215 care network in order to strengthen its particular fiscal
216 viability.
217 (e) After a recipient has made a selection or has been
218 enrolled in a capitated managed care network, the recipient
219 shall have 90 days in which to voluntarily disenroll and select
220 another capitated managed care network. After 90 days, no
221 further changes may be made except for cause. Cause shall
222 include, but not be limited to, poor quality of care, lack of
223 access to necessary specialty services, an unreasonable delay or
224 denial of service, inordinate or inappropriate changes of
225 primary care providers, service access impairments due to
226 significant changes in the geographic location of services, or
227 fraudulent enrollment. The agency may require a recipient to use
228 the capitated managed care network's grievance process as
229 specified in paragraph (3)(q) prior to the agency's
230 determination of cause, except in cases in which immediate risk
231 of permanent damage to the recipient's health is alleged. The
232 grievance process, when used, must be completed in time to
233 permit the recipient to disenroll no later than the first day of
234 the second month after the month the disenrollment request was
235 made. If the capitated managed care network, as a result of the
236 grievance process, approves an enrollee's request to disenroll,
237 the agency is not required to make a determination in the case.
238 The agency must make a determination and take final action on a
239 recipient's request so that disenrollment occurs no later than

240 the first day of the second month after the month the request
241 was made. If the agency fails to act within the specified
242 timeframe, the recipient's request to disenroll is deemed to be
243 approved as of the date agency action was required. Recipients
244 who disagree with the agency's finding that cause does not exist
245 for disenrollment shall be advised of their right to pursue a
246 Medicaid fair hearing to dispute the agency's finding. When a
247 specialty provider service network or specialty managed care
248 plan first becomes available in a geographic area, beneficiaries
249 meeting diagnostic criteria shall be offered an open enrollment
250 period during which they may choose to reenroll in a specialty
251 provider service network or specialty managed care plan.
252 Section 3. This act shall take effect July 1, 2008.
253
254
255
256 ---
257 **T I T L E A M E N D M E N T**
258 Remove the entire title and insert:
259 An act relating to Medicaid provider service networks;
260 amending s. 409.912, F.S.; authorizing the Agency for
261 Health Care Administration to contract with a specialty
262 provider service network that exclusively enrolls Medicaid
263 beneficiaries who have psychiatric disabilities; requiring
264 the specialty provider to offer the same physical and
265 behavioral health services that are required from other
266 Medicaid health maintenance organizations and provider
267 service networks; requiring that beneficiaries be assigned
268 to a specialty provider service network under certain
269 circumstances; amending s. 409.91211, F.S.; requiring that
270 the agency modify eligibility assignment processes for

271 managed care pilot programs to include specialty plans
272 that specialize in care for beneficiaries who have
273 psychiatric disabilities; requiring the agency to provide
274 a service delivery alternative to provide Medicaid
275 services to persons having psychiatric disabilities;
276 providing an additional criterion for the agency in making
277 assignments; requiring that enrollment and choice
278 counseling materials contain an explanation concerning the
279 choice of a network or plan; providing for an additional
280 open enrollment period following the availability of
281 specialty services; providing an effective date.
282
283

1 A bill to be entitled
2 An act relating to Medicaid recipients with psychiatric
3 disabilities ; amending s. 409.912, F.S.; authorizing the
4 Agency for Health Care Administration to contract with
5 certain service networks that enroll Medicaid recipients
6 with psychiatric disabilities; providing for recipients
7 with psychiatric disabilities to be assigned to a
8 specified service network under certain circumstances;
9 amending s. 409.91211, F.S.; revising duties of the agency
10 to include contracting with provider service networks
11 specializing in care for Medicaid recipients with
12 psychiatric disabilities; revising criteria for assignment
13 of certain Medicaid recipients; providing an effective
14 date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Paragraph (d) of subsection (4) of section
19 409.912, Florida Statutes, is amended to read:
20 409.912 Cost-effective purchasing of health care.--The
21 agency shall purchase goods and services for Medicaid recipients
22 in the most cost-effective manner consistent with the delivery
23 of quality medical care. To ensure that medical services are
24 effectively utilized, the agency may, in any case, require a
25 confirmation or second physician's opinion of the correct
26 diagnosis for purposes of authorizing future services under the
27 Medicaid program. This section does not restrict access to
28 emergency services or poststabilization care services as defined

29 in 42 C.F.R. part 438.114. Such confirmation or second opinion
30 shall be rendered in a manner approved by the agency. The agency
31 shall maximize the use of prepaid per capita and prepaid
32 aggregate fixed-sum basis services when appropriate and other
33 alternative service delivery and reimbursement methodologies,
34 including competitive bidding pursuant to s. 287.057, designed
35 to facilitate the cost-effective purchase of a case-managed
36 continuum of care. The agency shall also require providers to
37 minimize the exposure of recipients to the need for acute
38 inpatient, custodial, and other institutional care and the
39 inappropriate or unnecessary use of high-cost services. The
40 agency shall contract with a vendor to monitor and evaluate the
41 clinical practice patterns of providers in order to identify
42 trends that are outside the normal practice patterns of a
43 provider's professional peers or the national guidelines of a
44 provider's professional association. The vendor must be able to
45 provide information and counseling to a provider whose practice
46 patterns are outside the norms, in consultation with the agency,
47 to improve patient care and reduce inappropriate utilization.
48 The agency may mandate prior authorization, drug therapy
49 management, or disease management participation for certain
50 populations of Medicaid beneficiaries, certain drug classes, or
51 particular drugs to prevent fraud, abuse, overuse, and possible
52 dangerous drug interactions. The Pharmaceutical and Therapeutics
53 Committee shall make recommendations to the agency on drugs for
54 which prior authorization is required. The agency shall inform
55 the Pharmaceutical and Therapeutics Committee of its decisions
56 regarding drugs subject to prior authorization. The agency is

57 authorized to limit the entities it contracts with or enrolls as
58 Medicaid providers by developing a provider network through
59 provider credentialing. The agency may competitively bid single-
60 source-provider contracts if procurement of goods or services
61 results in demonstrated cost savings to the state without
62 limiting access to care. The agency may limit its network based
63 on the assessment of beneficiary access to care, provider
64 availability, provider quality standards, time and distance
65 standards for access to care, the cultural competence of the
66 provider network, demographic characteristics of Medicaid
67 beneficiaries, practice and provider-to-beneficiary standards,
68 appointment wait times, beneficiary use of services, provider
69 turnover, provider profiling, provider licensure history,
70 previous program integrity investigations and findings, peer
71 review, provider Medicaid policy and billing compliance records,
72 clinical and medical record audits, and other factors. Providers
73 shall not be entitled to enrollment in the Medicaid provider
74 network. The agency shall determine instances in which allowing
75 Medicaid beneficiaries to purchase durable medical equipment and
76 other goods is less expensive to the Medicaid program than long-
77 term rental of the equipment or goods. The agency may establish
78 rules to facilitate purchases in lieu of long-term rentals in
79 order to protect against fraud and abuse in the Medicaid program
80 as defined in s. 409.913. The agency may seek federal waivers
81 necessary to administer these policies.
82 (4) The agency may contract with:
83 (d) A provider service network, which may be reimbursed on
84 a fee-for-service or prepaid basis. A provider service network

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

85 which is reimbursed by the agency on a prepaid basis shall be
86 exempt from parts I and III of chapter 641, but must comply with
87 the solvency requirements in s. 641.2261(2) and meet appropriate
88 financial reserve, quality assurance, and patient rights
89 requirements as established by the agency. The agency is
90 authorized to contract with specialty provider service networks
91 that exclusively enroll Medicaid recipients with psychiatric
92 disabilities.
93 1. Except as provided in subparagraph 2., Medicaid
94 recipients assigned to a provider service network shall be
95 chosen equally from those who would otherwise have been assigned
96 to prepaid plans and MediPass. The agency is authorized to seek
97 federal Medicaid waivers as necessary to implement the
98 provisions of this section. Any contract previously awarded to a
99 provider service network operated by a hospital pursuant to this
100 subsection shall remain in effect for a period of 3 years
101 following the current contract expiration date, regardless of
102 any contractual provisions to the contrary. A provider service
103 network is a network established or organized and operated by a
104 health care provider, or group of affiliated health care
105 providers, including minority physician networks and emergency
106 room diversion programs that meet the requirements of s.
107 409.91211, which provides a substantial proportion of the health
108 care items and services under a contract directly through the
109 provider or affiliated group of providers and may make
110 arrangements with physicians or other health care professionals,
111 health care institutions, or any combination of such individuals
112 or institutions to assume all or part of the financial risk on a

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

113 prospective basis for the provision of basic health services by
114 the physicians, by other health professionals, or through the
115 institutions. The health care providers must have a controlling
116 interest in the governing body of the provider service network
117 organization.
118 2. A Medicaid recipient with psychiatric disabilities who
119 fails to select a managed care plan shall be assigned to a
120 provider service network that exclusively enrolls Medicaid
121 recipients with psychiatric disabilities, if such program is
122 available in the geographic area where the recipient resides.
123 Section 2. Paragraph (a) of subsection (4) of section
124 409.91211, Florida Statutes, is amended, and paragraph (ee) is
125 added to subsection (3) of that section, to read:
126 409.91211 Medicaid managed care pilot program.--
127 (3) The agency shall have the following powers, duties,
128 and responsibilities with respect to the pilot program:
129 (ee) To seek applications for and contract with provider
130 service networks specializing in care for recipients with
131 psychiatric disabilities. The agency shall develop and implement
132 a definition of psychiatric disabilities for membership and
133 assignment purposes and establish assignment processes for
134 recipients with psychiatric disabilities who fail to choose a
135 managed care plan.
136 (4)(a) A Medicaid recipient in the pilot area who is not
137 currently enrolled in a capitated managed care plan upon
138 implementation is not eligible for services as specified in ss.
139 409.905 and 409.906, for the amount of time that the recipient
140 does not enroll in a capitated managed care network. If a

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

141 Medicaid recipient has not enrolled in a capitated managed care
142 plan within 30 days after eligibility, the agency shall assign
143 the Medicaid recipient to a capitated managed care plan based on
144 the assessed needs of the recipient as determined by the agency
145 and the recipient shall be exempt from s. 409.9122. When making
146 assignments, the agency shall take into account the following
147 criteria:

148 1. A capitated managed care network has sufficient network
149 capacity to meet the needs of members.

150 2. The capitated managed care network has previously
151 enrolled the recipient as a member, or one of the capitated
152 managed care network's primary care providers has previously
153 provided health care to the recipient.

154 3. The agency has knowledge that the member has previously
155 expressed a preference for a particular capitated managed care
156 network as indicated by Medicaid fee-for-service claims data,
157 but has failed to make a choice.

158 4. The capitated managed care network's primary care
159 providers are geographically accessible to the recipient's
160 residence.

161 5. The existence of any known diagnoses or disabilities,
162 including psychiatric disabilities.

163 Section 3. This act shall take effect July 1, 2008.

Medicaid Durable Medical
Equipment Fraud

1 A bill to be entitled
2 An act relating to ; providing an effective date.
3
4 Be It Enacted by the Legislature of the State of Florida:
5
6 Section 1. Subsections (5), (6), (7), (8), (9), (10),
7 (11), (12), (13), (14), (15), (16), (17), (18), (19), (20),
8 (22), (23), (24), (25), (26), and (27) of section 409.901,
9 Florida Statutes, are renumbered as subsections (6), (7), (8),
10 (9), (10), (11), (12), (13), (14), (15), (16), (17), (18), (19),
11 (20), (22), (23), (24), (25), (26), (27) and (28), respectively,
12 and a new subsection (5) is added to that section to read:
13 409.901 Definitions; ss. 409.901-409.920.--As used in ss.
14 409.901-409.920, except as otherwise specifically provided, the
15 term:
16 (5) "Change of ownership" means an event in which the
17 provider changes to a different legal entity or in which 45
18 percent or more of the ownership, voting shares, or controlling
19 interest in a corporation whose shares are not publicly traded
20 on a recognized stock exchange is transferred or assigned,
21 including the final transfer or assignment of multiple transfers
22 or assignments over a 2-year period that cumulatively total 45
23 percent or greater. A change solely in the management company or
24 board of directors is not a change of ownership.
25 Section 2. Subsection (6), and subsection (9) of section
26 409.907, Florida Statutes, are amended to read:
27 409.907 Medicaid provider agreements.--The agency may make
28 payments for medical assistance and related services rendered to

29 Medicaid recipients only to an individual or entity who has a
30 provider agreement in effect with the agency, who is performing
31 services or supplying goods in accordance with federal, state,
32 and local law, and who agrees that no person shall, on the
33 grounds of handicap, race, color, or national origin, or for any
34 other reason, be subjected to discrimination under any program
35 or activity for which the provider receives payment from the
36 agency.
37 (6) A Medicaid provider agreement may be revoked, at the
38 option of the agency, as the result of a change of ownership of
39 any facility, association, partnership, or other entity named as
40 the provider in the provider agreement. A provider shall give
41 the agency 60 days' notice before making any change in ownership
42 of the entity named in the provider agreement as the provider.
43 (a) In the event of a change of ownership, the Medicaid
44 provider agreement shall be assigned to the transferee if the
45 transferee meets all other Medicaid provider qualifications. The
46 transferor shall remain liable for all outstanding overpayments,
47 administrative fines, and any other moneys owed to the agency
48 prior to the effective date of the change of ownership. In
49 addition to the continuing liability of the transferor, the
50 transferee shall be liable to the agency for all outstanding
51 overpayments identified by the agency on or before the effective
52 date of the change of ownership. For purposes of this
53 subsection, the term "outstanding overpayment" includes any
54 amount identified in a preliminary audit report issued to the
55 transferor by the agency on or before the effective date of the
56 change of ownership.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

V

57 (b) At least 60 days prior to the anticipated date of the
58 change of ownership, the transferor shall notify the agency of
59 the intended change of ownership and the transferee shall submit
60 to the agency a Medicaid provider enrollment application. In the
61 event a change of ownership occurs without compliance with the
62 notice requirements of this subsection, the transferor and
63 transferee shall be jointly and severally liable for all
64 overpayments, administrative fines, and any other moneys due to
65 the agency, regardless of whether the agency identified the
66 overpayments, administrative fines, or other moneys before or
67 after the effective date of the change of ownership. The agency
68 shall not approve a transferee's Medicaid provider enrollment
69 application if the transferee or transferor has not paid or
70 agreed in writing to a payment plan for all outstanding
71 overpayments, administrative fines, and other moneys due to the
72 agency. Nothing in this subsection is intended to preclude the
73 agency from seeking any other legal or equitable remedies
74 available to the agency for the recovery of moneys owed to the
75 Medicaid program.
76 (9) Upon receipt of a completed, signed, and dated
77 application, and completion of any necessary background
78 investigation and criminal history record check, the agency must
79 either:
80 (a) Enroll the applicant as a Medicaid provider upon
81 approval of the provider application. The enrollment effective
82 date shall be the date the agency receives the provider
83 application. With respect to providers that require a Medicare
84 certification survey, the enrollment effective date shall be the

85 date the certification is awarded. With respect to providers
86 that complete changes of ownership, upon approval of the
87 provider application, the enrollment effective date will be the
88 date the change of ownership was effective. Payment for any
89 claims for services provided to Medicaid recipients between the
90 date of receipt of the application and the date of approval is
91 contingent on applying any and all applicable audits and edits
92 contained in the agency's claims adjudication and payment
93 processing systems; or
94 (b) Deny the application if the agency finds that it is in
95 the best interest of the Medicaid program to do so. The agency
96 may consider the factors listed in subsection (10), as well as
97 any other factor that could affect the effective and efficient
98 administration of the program, including, but not limited to,
99 the applicant's demonstrated ability to provide services,
100 conduct business, and operate a financially viable concern; the
101 current availability of medical care, services, or supplies to
102 recipients, taking into account geographic location and
103 reasonable travel time; the number of providers of the same type
104 already enrolled in the same geographic area; and the
105 credentials, experience, success, and patient outcomes of the
106 provider for the services that it is making application to
107 provide in the Medicaid program. The agency shall deny the
108 application if the agency finds that a provider; any officer,
109 director, agent, managing employee, or affiliated person; or any
110 partner or shareholder having an ownership interest equal to 5
111 percent or greater in the provider if the provider is a
112 corporation, partnership, or other business entity, has failed

113 to pay all outstanding fines or overpayments assessed by final
114 order of the agency or final order of the Centers for Medicare
115 and Medicaid Services, not subject to further appeal, unless the
116 provider agrees to a repayment plan that includes withholding
117 Medicaid reimbursement until the amount due is paid in full.
118 Section 3. Subsection (48) of section 409.912, Florida
119 Statutes, is amended to read:
120 409.912 Cost-effective purchasing of health care.--The
121 agency shall purchase goods and services for Medicaid recipients
122 in the most cost-effective manner consistent with the delivery
123 of quality medical care. To ensure that medical services are
124 effectively utilized, the agency may, in any case, require a
125 confirmation or second physician's opinion of the correct
126 diagnosis for purposes of authorizing future services under the
127 Medicaid program. This section does not restrict access to
128 emergency services or poststabilization care services as defined
129 in 42 C.F.R. part 438.114. Such confirmation or second opinion
130 shall be rendered in a manner approved by the agency. The agency
131 shall maximize the use of prepaid per capita and prepaid
132 aggregate fixed-sum basis services when appropriate and other
133 alternative service delivery and reimbursement methodologies,
134 including competitive bidding pursuant to s. 287.057, designed
135 to facilitate the cost-effective purchase of a case-managed
136 continuum of care. The agency shall also require providers to
137 minimize the exposure of recipients to the need for acute
138 inpatient, custodial, and other institutional care and the
139 inappropriate or unnecessary use of high-cost services. The
140 agency shall contract with a vendor to monitor and evaluate the

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

141 clinical practice patterns of providers in order to identify
142 trends that are outside the normal practice patterns of a
143 provider's professional peers or the national guidelines of a
144 provider's professional association. The vendor must be able to
145 provide information and counseling to a provider whose practice
146 patterns are outside the norms, in consultation with the agency,
147 to improve patient care and reduce inappropriate utilization.
148 The agency may mandate prior authorization, drug therapy
149 management, or disease management participation for certain
150 populations of Medicaid beneficiaries, certain drug classes, or
151 particular drugs to prevent fraud, abuse, overuse, and possible
152 dangerous drug interactions. The Pharmaceutical and Therapeutics
153 Committee shall make recommendations to the agency on drugs for
154 which prior authorization is required. The agency shall inform
155 the Pharmaceutical and Therapeutics Committee of its decisions
156 regarding drugs subject to prior authorization. The agency is
157 authorized to limit the entities it contracts with or enrolls as
158 Medicaid providers by developing a provider network through
159 provider credentialing. The agency may competitively bid single-
160 source-provider contracts if procurement of goods or services
161 results in demonstrated cost savings to the state without
162 limiting access to care. The agency may limit its network based
163 on the assessment of beneficiary access to care, provider
164 availability, provider quality standards, time and distance
165 standards for access to care, the cultural competence of the
166 provider network, demographic characteristics of Medicaid
167 beneficiaries, practice and provider-to-beneficiary standards,
168 appointment wait times, beneficiary use of services, provider

169 turnover, provider profiling, provider licensure history,
170 previous program integrity investigations and findings, peer
171 review, provider Medicaid policy and billing compliance records,
172 clinical and medical record audits, and other factors. Providers
173 shall not be entitled to enrollment in the Medicaid provider
174 network. The agency shall determine instances in which allowing
175 Medicaid beneficiaries to purchase durable medical equipment and
176 other goods is less expensive to the Medicaid program than long-
177 term rental of the equipment or goods. The agency may establish
178 rules to facilitate purchases in lieu of long-term rentals in
179 order to protect against fraud and abuse in the Medicaid program
180 as defined in s. 409.913. The agency may seek federal waivers
181 necessary to administer these policies.
182 (48) <u>(a)</u> A provider is not entitled to enrollment in the
183 Medicaid provider network. The agency may implement a Medicaid
184 fee-for-service provider network controls, including, but not
185 limited to, competitive procurement and provider credentialing.
186 If a credentialing process is used, the agency may limit its
187 provider network based upon the following considerations:
188 beneficiary access to care, provider availability, provider
189 quality standards and quality assurance processes, cultural
190 competency, demographic characteristics of beneficiaries,
191 practice standards, service wait times, provider turnover,
192 provider licensure and accreditation history, program integrity
193 history, peer review, Medicaid policy and billing compliance
194 records, clinical and medical record audit findings, and such
195 other areas that are considered necessary by the agency to
196 ensure the integrity of the program.

197 (b) The agency shall limit its network of durable medical
198 equipment and medical supply providers. The agency shall not
199 provide reimbursement for durable medical equipment and medical
200 supplies and services provided to recipients after January 1,
201 2009, by providers that do not meet the requirements of this
202 subsection.
203 1. Providers must be accredited by the Joint Commission
204 on Accreditation of Healthcare Organizations. Each provider
205 must be re-accredited periodically and shall be subject to
206 unannounced reviews by the accrediting organization. The
207 following providers are exempt from this requirement:
208 a. Durable medical equipment providers owned and operated
209 by a government entity.
210 b. Durable medical equipment providers that are operating
211 within a pharmacy that is currently enrolled as a Medicaid
212 pharmacy provider.
213 c. Active, Medicaid-enrolled orthopedic physician groups,
214 primarily owned by physicians, providing only orthotic and
215 prosthetic devices.
216 2. Providers must provide the services or supplies
217 directly to the Medicaid recipient whether in person or by
218 receipt of mailed delivery. Subcontracting or consignment of
219 the service or supply to a third party is prohibited.
220 3. Providers must legally occupy a physical business
221 location clearly identified as a business that furnishes durable
222 medical equipment or medical supplies by signage which can be
223 read from 20 feet away. The location must be readily accessible
224 to the public during posted business hours and must operate no

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

225 less than five (5) hours per day and no less than five (5) days
226 per week, with the exception of scheduled and posted holidays,
227 and must have a functional landline business phone. The
228 location shall not be located within or at the same numbered
229 street address as another enrolled Medicaid durable medical
230 equipment or medical supply provider or as an enrolled Medicaid
231 pharmacy that is also enrolled as a durable medical equipment
232 provider. The location shall be within the state of Florida or
233 no more than fifty (50) miles from the Florida state line. The
234 agency may make exceptions for providers of durable medical
235 equipment or supplies not otherwise available from other
236 enrolled providers located within the state.
237 4. Providers must maintain at the physical location an
238 inventory that is readily available to meet the needs of the
239 durable medical equipment business location's customers.
240 5. Providers must post a $50,000 surety bond for each
241 provider location, up to a maximum of five (5) bonds statewide
242 or an aggregate bond of $250,000 statewide as identified per
243 Federal Employer Identification Number. Providers who post a
244 statewide or an aggregate bond must identify all of their
245 locations in any Medicaid durable medical equipment and medical
246 supply provider enrollment application or bond renewal. Each
247 provider location's surety bond must be renewed annually and the
248 provider must submit proof of renewal even if the original bond
249 is a continuous bond. The following providers are exempt from
250 this requirement:
251 a. Durable medical equipment providers owned and operated
252 by a government entity.

253 b. Durable medical equipment providers that are operating
254 within a pharmacy that is currently enrolled as a Medicaid
255 pharmacy provider.
256 c. Active, Medicaid-enrolled orthopedic physician groups,
257 primarily owned by physicians, providing only orthotic and
258 prosthetic devices.
259 6. Providers must obtain a Level Two background screening,
260 as described in section 435.04, for each provider employee in
261 direct contact with or providing direct services to Medicaid
262 recipients in their homes, and shall ensure such screening is
263 required as a condition of employment. This requirement
264 includes, but is not limited to, repair and service technicians,
265 fitters and delivery staff. The cost of the background
266 screening shall be borne by the provider.
267 Section 4. This act shall take effect July 1, 2008.