The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Children, Families, and Elder Affairs Committee

BILL:	CS/SB 476
INTRODUCER:	The Children, Families and Elder Affairs Committee and Senators Altman, Sobel and Detert
SUBJECT:	Medicaid/Behavioral Health Services
DATE:	April 7, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Bell	Wilson	HR	**Fav/1 Amendment**
2.	Hansson	Walsh	CF	**Fav/CS**
3.			HA	
4.			WPSC	
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The committee substitute requires the funds returned to the Agency for Health Care Administration (Agency) from behavioral health plans that do not spend at least 80 percent of their capitation rate on behavioral health care services, as required by law, to be deposited in the Medical Care Trust Fund and reallocated to the community behavioral health providers in the network that provided Medicaid services. Providers must use the funds for any Medicaid-allowable type of community behavioral health and case management service. The bill requires community behavioral health agencies enrolled in the provider network of a managed care plan that failed to meet the 80 percent requirement to submit specified encounter data and medical necessity information, which will be the basis for the fee-for-service reimbursement.

This bill substantially amends s. 409.912, F.S.

II. Present Situation:

Publicly funded substance abuse and mental health services (also known as behavioral health care services) in Florida are primarily provided or coordinated through the Department of

Children and Family Services (DCF). Section 394.9082, F.S., directs the DCF and the Agency to develop service delivery strategies to improve the coordination, integration and management of the delivery of mental health and substance abuse services. The DCF and the Agency are authorized to contract with managing entities for the provision of behavioral health care services. The managing entity concept provides an umbrella organization that subcontracts with a network of substance abuse and/or mental health service providers in a geographic region. The managing entity is responsible for oversight of subcontractors, and the DCF's relationship is primarily with the managing entity contractor.

Florida Medicaid Program

Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The Agency is the single state agency responsible for the Florida Medicaid Program.[1]

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[2] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[3] Similarly, some eligibility categories are mandatory[4] and some are optional.[5] Payments for services to individuals in the optional eligibility categories are subject to the availability of monies and any limitations established by the General Appropriations Act or ch. 216, F.S. For fiscal year 2010-2011, the Florida Medicaid Program is projected to cover 2.9 million people[6] at an estimated cost of $19.1 billion.[7]

The Agency maintains a network of Medicaid providers, including individual health care practitioners, health care facilities, and other entities to provide services to Medicaid recipients.[8] The Agency executes a provider agreement, as specified in s. 409.907, F.S., with each individual Medicaid provider. The Agency has contractual arrangements with seventeen Medicaid HMOs that provide services to over 1 million Medicaid recipients.[9] Approximately two-thirds of all Medicaid recipients are enrolled in some type of Medicaid managed care.[10]

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[1] The statutory provisions for the Medicaid program appear in ss. 409.901-409.9205, F.S.
[2] These mandatory services are codified in s. 409.905, F.S.
[3] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.
[4] Section 409.903, F.S.
[5] Section 409.904, F.S.
[6] Social Services Estimating Conference, Medicaid Caseload, January 26, 2010. Found at: <http://edr.state.fl.us/conferences/medicaid/medcases.pdf> (Last visited on April 5, 2010).
[7] Social Services Estimating Conference, Medicaid Services Expenditures, February 12, 2010. Found at: < http://edr.state.fl.us/conferences/medicaid/medhistory.pdf> (Last visited on April 5, 2010).
[8] The Agency currently has Medicaid provider agreements with 104,004 providers statewide, including: 37,883 physicians; 44 hospices; and 650 nursing homes.
[9] Agency for Health Care Administration, Comprehensive Medicaid Managed Care Enrollment Report, February 10, 2010. Found at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml> (Last visited on April 5, 2010).
[10] Agency for Health Care Administration, Comprehensive Medicaid Managed Care Enrollment Report, February 10, 2010. Found at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml> (Last visited on April 5, 2010).

Medicaid Managed Care Programs

The state of Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[11] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is divided into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program.

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and referral and authorization for specialty services and hospital care. The primary care providers are expected to monitor appropriateness of health care provided to their patients. MediPass providers receive a $2 monthly case management fee for each of their enrolled patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered. Currently, there are 2,482 enrolled Medicaid provider practices that include 5,087 individual providers.[12]

The second major category of provider in the Medicaid managed care program is the managed care plan. Section 409.9122, F.S., defines managed care plans as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), provider service networks (PSNs), minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs. Most of these plans are reimbursed through a capitated payment where the plan receives a set amount per member per month and is responsible for providing all necessary Medicaid services within that capitation rate.

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., the Agency is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not make a choice within 30 days of eligibility.

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[11] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

[12] Agency for Health Care Administration, Managed Care in Florida, Presentation before the Senate Ways and Means Committee, February 17, 2010. Found at: <http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/managed_care_in_fl_medicaid_02-17-2010.pdf> (Last visited April 5, 2010).

As of February 2010, there were 2,659,311 individuals enrolled in the Florida Medicaid program. Of these Medicaid recipients, 257,584 were enrolled in the Medicaid reform pilot and 884,991 were enrolled in HMOs.[13]

Medicaid Behavioral Health Care Services

Behavioral health care services are an optional Medicaid service under s. 409.906(8), F.S. The law provides that the Agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider under contract with the Agency or the DCF. The Agency provides reimbursement for mental health targeted case management and community behavioral health care services. The DCF Mental Health Program Office, in conjunction with the Medicaid program, is responsible for approving policy for the Medicaid mental health management program.[14] The DCF is responsible for collaborating with and joint development of all behavioral health Medicaid policies, budgets, procurement documents, contracts and monitoring plans.[15] The Agency is required to offer eligible community mental health providers, child welfare providers, and mental health providers,[16] the opportunity to participate in any Medicaid provider network for prepaid behavioral health care services.

Medicaid Prepaid Behavioral Health Plans

In March 1996, the Agency implemented a Prepaid Mental Health Plan (PMHP) demonstration, under the authority of the 1915(b) Medicaid managed care waiver. The program was piloted in two areas of the state before being expanded statewide in 2004, and is codified in s. 409.912(4), F.S. A prepaid behavioral health plan is a managed care organization that contracts with the Agency to provide comprehensive behavioral health care services to its members through a capitated payment system. The Agency pays a per member, per month (PMPM) fee to the plan based on the age and eligibility category of each member. Services provided by these plans must include:

- Inpatient psychiatric hospital services (45 days for adult recipients and 365 days for children);
- Outpatient psychiatric hospital services;
- Psychiatric physician services;
- Community mental health services; and
- Mental health targeted case management.

Medicaid recipients who elect to enroll in MediPass for the provision of their physical health care services are assigned to a prepaid behavioral health plan for the provision of their mental health services, unless they are ineligible. Ineligible persons include:[17]

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[13] Agency for Health Care Administration, Comprehensive Medicaid Managed Care Reports, February 2010. Found at: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml (Last visited on April 5, 2010).

[14] See, Florida Medicaid, Mental Health Targeted Case Management Handbook. Found at: <http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_07_070601_MH_Case_Mgmt_ver2.2.pdf> (Last visited on April 5, 2010).

[15] s. 409.912(4), F.S.

[16] Eligible providers include community mental health providers under contract with DCF under part IV of ch. 394, F.S., child welfare providers under contract with DCF in areas 1 and 6, and mental health providers licensed pursuant to ch. 395, F.S.

[17] Agency for Health Care Administration, Managed Care in Florida, Presentation before the Senate Ways and Means Committee, February 17, 2010. Found at:

- Recipients who have both Medicaid and Medicare coverage (dual eligibles),
- Persons living in an institutional setting, such as a nursing home, state mental health treatment facility, or prison,
- Medicaid-eligible recipients receiving services through hospice,
- Recipients in the Medically Needy Program,
- Newly-enrolled recipients who have not yet chosen a health plan,
- SOBRA-eligible pregnant women and presumptively eligible pregnant women,
- Individuals with private major medical coverage,
- Members of a Medicaid HMO if the HMO has chosen to provide behavioral health services,
- Recipients receiving FACT services, and
- Children enrolled in the HomeSafeNet database, unless they are enrolled in a Medicaid reform managed care plan in Broward County.

Because of their unique situation, children in the HomeSafeNet database are excluded from participating in a prepaid behavioral health plan. A separate prepaid plan, operated by community based lead agencies that are contracted through the DCF, was developed for these children to provide services (including behavioral health care services) as of July 1, 2005.

Prepaid behavioral health plans under s. 409.912(4)(b), F.S., are required to spend 80 percent of the capitation rate paid to the plan for the provision of behavioral health care services. If a plan spends less than 80 percent of its behavioral health capitation rate on behavioral health care services, then the difference must be returned to the Agency. The Agency is required to provide each managed care plan that covers behavioral health services a letter that indicates the amount of capitation paid during each calendar year for behavioral health care services. Medicaid HMOs that provide behavioral health care services must also meet the 80 percent requirement.

Medicaid beneficiaries who choose to enroll in MediPass are automatically enrolled into prepaid behavioral health plans for behavioral health care services. Beneficiaries who choose to enroll in a Medicaid HMO, receive their behavioral health care services through the HMO. In Medicaid reform areas, behavioral health care services are provided through HMOs or PSNs.

III. Effect of Proposed Changes:

The bill amends s. 409.912(4), F.S., to specify that any funds returned to the Agency by prepaid behavioral health plans that do not utilize at least 80 percent of the capitation rate paid to the plan for the provision of behavioral health care services, as required by law, must be deposited into the Medical Care Trust Fund. The Agency must maintain a separate accounting of these funds. After the Agency has returned the federal portion of Medicaid matching funds to the federal government, the Agency must allocate the remaining funds to community behavioral health providers enrolled in the network of the managed care organization that made the repayments.

The bill specifies that the funds will be allocated in proportion to each community behavioral health agency's earnings from the managed care plan making the repayment. The providers are

<http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/managed_care_in_fl_medicaid_02-17-2010.pdf> (Last visited April 5, 2010).

directed to use the funds for any Medicaid allowable type of community behavioral health and case management service.

The community behavioral health agencies will be reimbursed by Agency on a fee-for-service basis for allowable services up to their redistribution amount. The bill requires reinvestment amounts to be calculated on an annual basis, within 60 days after managed care plans file their annual 80 percent spending reports.

Community behavioral health agencies enrolled in the provider network of a managed care plan that failed to meet the 80 percent spending requirement must submit encounter data information on all claims not paid by the health plan for the fiscal year in which the 80 percent requirement was not met and appropriate documentation demonstrating medical necessity for the services provided. The encounter data will be the basis for the fee-for-service reimbursement to the agencies.

The bill removes the provision in current law that requires the Agency to provide each Medicaid prepaid behavioral health plan with a certification letter indicating that amount of capitation paid for behavioral health services during the calendar year.

The effective date of the bill is July 1, 2010.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Community behavioral health providers may receive additional Medicaid reimbursements if the provisions in the bill are adopted.

C. Government Sector Impact:

The bill requires the funds returned to the Agency from the Medicaid managed care plans that provide behavioral health care services that do not spend 80 percent of their behavioral health capitation on behavioral health care services to be reinvested in community behavioral health care. In 2008, eight of the 14 Medicaid managed care plans providing behavioral health care services returned $6 million under this program. Approximately 50-60 percent of the funds were returned to the federal government.[18]

The redistribution of funds in the bill may negatively impact Medicaid programs or services that had previously received the funds.

The bill would increase the amount of state funds supporting behavioral health care in Florida.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Agency has indicated that it does not currently have access to the information it would need to implement the provision on lines 265-268 of the bill that requires the Agency to distribute returned funds in proportion to each community behavioral health agency's earnings from the Medicaid behavioral health plan returning funds to the Agency.[19]

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on April 7, 2010:
The committee substitute clarifies the method by which the community health providers will be reimbursed by the Agency. The committee substitute requires community behavioral health agencies enrolled in the provider network of a managed care plan that failed to meet the 80 percent requirement to submit specified encounter data and medical necessity information. The committee substitute also provides that such encounter data will be the basis for the fee-for-service reimbursement.

B. Amendments:

None.

[18] Telephone correspondence with Agency for Health Care Administration staff, March 15, 2010.
[19] Agency for Health Care Administration 2010 Bill Analysis & Economic Impact Statement, SB 476, on file with Senate Health Regulation Committee staff.