



April 16, 2009

Ms. Holly Benson
Secretary, Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

RE: Medicaid Recipients Wrongfully Removed From Prepaid Mental Health Plans and Denied Choice on Conversion of PSN to HMO

Dear Secretary Benson:

I am writing today on behalf of Florida CHAIN concerning a recent series of events in Miami-Dade and Tampa Bay and the adverse impact they have had on Medicaid recipients with mental illnesses.

As you know, the Florida Legislature in 2005 expanded the successful Medicaid Prepaid Mental Health Plan statewide. The Florida Mental Health Institute of the University of South Florida lauded the Legislature's plan for saving costs without sacrificing quality. Today, over 400,000 Medicaid recipients are enrolled in a plan designed especially for those with mental health disorders.

However, this year, thousands of Medicaid recipients have been effectively re-assigned from their PSN (Access Health Solutions or NetPass) to an HMO (Sunshine State Health Plan or Molina Health Plan) as a result of the purchase and conversion of those PSNs. These forced re-assignments occurred without the consent of recipients in 4 counties to-date: Hillsborough, Pinellas, Pasco and Miami-Dade counties, and they are expected to occur in other Florida counties as well.

Many of these affected recipients are seriously emotionally disturbed children and severely mentally ill adults who specifically chose to enroll in these PSNs in order to continue their participation in the prepaid mental health plans that have provided them with a medical home for mental health issues. Re-assignment to an HMO is especially problematic because it eliminates access to the prepaid mental health plan associated with that PSN.

As a result of the conversion, however, these recipients have been switched to a completely different type of managed care plan with a different approach to coordination of care and utilization management. **Most disconcerting of all, the forced transfer of prepaid mental health plan enrollees has occurred without prior choice counseling or the opportunity to select the option (i.e., MediPass) that allows for continuity of care.**

This backdoor expansion of HMOs is highly problematic. In particular, the Agency's actions (or inactions) appear to run afoul of federal and state Medicaid regulations as follows:

1. Federal Medicaid regulations require that managed care plan enrollees be notified about the change and its potential impact, prior to implementation.



- a. These PSNs are considered Prepaid Ambulatory Health Plans (PAHPs) for purposes of federal Medicaid regulations¹, a managed care model that is separate and distinct from Managed Care Organizations (MCOs), which include HMOs.
 - b. Among other federal requirements, PAHP enrollees must be provided with specific information about the plan. Examples of information that must be supplied include²:
 - Any restrictions on the enrollee's freedom of choice among network providers.
 - Enrollee rights and protections...
 - Information on grievance and fair hearing procedures...
 - The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
 - Procedures for obtaining benefits, including authorization requirements.
 - The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.
 - Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
 - c. Medicaid regulations also require that each enrollee of a PAHP (or any other managed care plan) be given written notice of any change in that information that the State deems significant, at least 30 days before the intended effective date of the change.³
2. The State clearly recognizes the significance of the conversion and its consequences.
 - a. The change alters the fundamental nature of the relationship between the recipient and the plan, including but not limited to those issues cited in 1b above. On that basis alone, the change is significant. More specifically, under State law, PSNs and HMOs are clearly distinct types of plans⁴, as are PAHPs and MCOs under federal regulations⁵. In this case, a PSN/PAHP has converted to an HMO/MCO.
 - b. A key element of the change is the transition from payment on a fee-for-service basis to a capitated basis. The Florida Legislature clearly considers such a transition to be a significant change. Indeed, within the Medicaid Reform Pilot, PSNs are given 3 years to transition to capitation⁶, and a 2-year extension on this deadline is currently under consideration this session⁷.
 3. The affected recipients had/have a good cause basis for seeking disenrollment.
 - a. The name, ownership, structure and configuration of the former PSNs have changed. There is no reasonable basis for asserting that the old plans exist and continue to operate in the affected counties.
 - b. State administrative rules require that if a recipient's health plan no longer participates in the county in which the recipient resides, he or she has good cause for disenrollment from the plan. The recipients should have been/should be afforded the opportunity to choose a different managed care option such as MediPass.⁸



4. This change constitutes an unsanctioned and unjustified expansion of Medicaid managed care in that enrollees of a less restrictive plan have been forced into a more restrictive one. This is an end-run around recipient choice and an expansion of the problematic approach taken in Medicaid Reform. The change at a minimum violates the intent of Florida’s approved federal 1115 Medicaid Waiver (i.e., Reform Pilot Program), which only allows the State to mandate enrollment in a managed care plan in the 5 Pilot counties.

Beyond what regulations specifically require, it’s important to note that prepaid mental health plans have proven themselves to be integral to an effective and efficient health care delivery system for persons with severe mental illnesses. Prepaid mental health plans hold promise as a medical home for severely mentally ill adults and seriously emotionally disturbed children, and the community mental health centers that deliver care within them provide recovery-oriented solutions and the best outcomes.

In conclusion, to best promote the health and well-being of vulnerable recipients as well to comply with both the letter and intent of applicable Medicaid regulations, **access to prepaid mental health plans must be preserved or, if already disrupted restored, until a strategy is crafted by the Legislature.**

We therefore request that the Agency take immediate steps to reverse the damage already done as well as to prevent further harm by ensuring that all former enrollees of the converted PSNs have the opportunity to make a meaningfully informed and assisted choice among available plans. **In particular, the Agency must aggressively seek to clarify that not only is MediPass an option, but also that it is *the* option that will restore/preserve access to mental health services via the prepaid mental health plan in which they were previously/are currently enrolled.**

Thank you in advance for your consideration of this proposed responses to yet another serious challenge within our Medicaid managed care system.

Sincerely,

Lisa Margulis Grossman
Interim Executive Director

cc: Mr. Dyke Snipes, AHCA Deputy Secretary for Medicaid
Ms. Charlene Frizzera, Acting Administrator, Centers for Medicare & Medicaid Services

1. See 42 CFR 438.10(b).
2. See 42 CFR 438.10(f)(6).
3. See 42 CFR 438.10(4).
4. See e.g., Section 409.912(4)(d), Florida Statutes, or [Florida’s Approved 1115 Medicaid Waiver Application](#) , pp.34-35.
5. See 42 CFR 438.2.
6. See s. 409.91211(3)(e), F.S.
7. See e.g., [CS for SB 1658, Section 16 \(2009\)](#).
8. See Section 59G-8.600(2)(g), Florida Administrative Code.