1 A bill to be entitled
2 An act relating to health care; amending s.
3 393.0661, F.S.; providing for additional hours
4 to be authorized under the personal care
5 assistance services provided pursuant to a
6 federal waiver program and administered by the
7 Agency for Health Care Administration;
8 repealing proviso language contained in
9 Specific Appropriation 270 in chapter 2007-72,
10 Laws of Florida, to conform; amending s.
11 395.701, F.S.; clarifying provisions imposing
12 an assessment on hospital outpatient services;
13 specifying assessment amounts; amending s.
14 409.908, F.S.; deleting a provision providing
15 that an operator of a Medicaid nursing home may
16 qualify for an increased reimbursement rate due
17 to a change of ownership or licensed operator;
18 providing a limitation on the reimbursement
19 rates for Medicaid payments to nursing homes;
20 amending s. 409.912, F.S.; providing for
21 certain children who are eligible for Medicaid
22 and who reside within a specified service area
23 of the Agency for Health Care Administration to
24 be served under a service delivery mechanism
25 other than the HomeSafeNet system; amending s.
26 409.9122, F.S.; requiring that the agency give
27 certain providers priority with respect to the
28 assignment of enrollees under the Medicaid
29 managed prepaid health plan; deleting a
30 requirement that certain recipients of
31 comprehensive behavioral health services be

1 assigned to MediPass or a managed care plan;
2 amending s. 409.91211, F.S.; clarifying the
3 duties of the agency for implementing service
4 delivery mechanisms for certain children who
5 are eligible for Medicaid; providing effective
6 dates.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Paragraph (f) of subsection (3) of section
11 393.0661, Florida Statutes, is amended to read:
12 393.0661 Home and community-based services delivery
13 system; comprehensive redesign.--The Legislature finds that
14 the home and community-based services delivery system for
15 persons with developmental disabilities and the availability
16 of appropriated funds are two of the critical elements in
17 making services available. Therefore, it is the intent of the
18 Legislature that the Agency for Persons with Disabilities
19 shall develop and implement a comprehensive redesign of the
20 system.
21 (3) The Agency for Health Care Administration, in
22 consultation with the agency, shall seek federal approval and
23 implement a four-tiered waiver system to serve clients with
24 developmental disabilities in the developmental disabilities
25 and family and supported living waivers. The agency shall
26 assign all clients receiving services through the
27 developmental disabilities waiver to a tier based on a valid
28 assessment instrument, client characteristics, and other
29 appropriate assessment methods. All services covered under the
30 current developmental disabilities waiver shall be available
31 to all clients in all tiers where appropriate, except as

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otherwise provided in this subsection or in the General Appropriations Act.

(f) The agency shall seek federal waivers and amend contracts as necessary to make changes to services defined in federal waiver programs administered by the agency as follows:

1. Supported living coaching services shall not exceed 20 hours per month for persons who also receive in-home support services.

2. Limited support coordination services shall be the only type of support coordination service provided to persons under the age of 18 who live in the family home.

3. Personal care assistance services shall be limited to no more than 180 hours per calendar month and shall not include rate modifiers. Additional hours may be authorized for persons who have intensive medical or adaptive needs and if such hours are essential for avoiding institutionalization, or for persons who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harming themselves or others. ~~Additional hours may be authorized only if a substantial change in circumstances occurs for the individual.~~

4. Residential habilitation services shall be limited to 8 hours per day. Additional hours may be authorized for persons who have intensive medical or adaptive needs and if such hours are essential for avoiding institutionalization, or for persons who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harming themselves or others. This restriction shall be in effect until the four-tiered waiver system is fully implemented.

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1 5. Chore Services, nonresidential support services,
2 and homemaker services shall be eliminated. The agency shall
3 expand the definition of in-home support services to enable
4 the provider of the service to include activities previously
5 provided in these eliminated services.
6 6. Massage therapy and psychological assessment
7 services shall be eliminated.
8 7. The agency shall conduct supplemental cost plan
9 reviews to verify the medical necessity of authorized services
10 for plans that have increased by more than 8 percent during
11 either of the 2 preceding fiscal years.
12 8. The agency shall implement a consolidated
13 residential habilitation rate structure to increase savings to
14 the state through a more cost-effective payment method and
15 establish uniform rates for intensive behavioral residential
16 habilitation services.
17 9. Pending federal approval, the agency is authorized
18 to extend current support plans for clients receiving services
19 under Medicaid waivers for 1 year beginning July 1, 2007, or
20 from the date approved, whichever is later. Clients who have a
21 substantial change in circumstances which threatens their
22 health and safety may be reassessed during this year in order
23 to determine the necessity for a change in their support plan.
24 Section 2. The following proviso associated with
25 Specific Appropriation 270 in chapter 2007-72, Laws of
26 Florida, is repealed: "Personal Care Assistance services shall
27 be limited to no more than 180 hours per calendar month and
28 shall not include rate modifiers. Additional hours may be
29 authorized only if a substantial change in circumstances
30 occurs for the individual."
31

1 Section 3. Subsection (2) of section 395.701, Florida
2 Statutes, is amended to read:
3 395.701 Annual assessments on net operating revenues
4 for inpatient and outpatient services to fund public medical
5 assistance; administrative fines for failure to pay
6 assessments when due; exemption.--
7 (2)(a) There is imposed upon each hospital an
8 assessment in an amount equal to 1.5 percent of the annual net
9 operating revenue for inpatient services for each hospital,
10 such revenue to be determined by the agency, based on the
11 actual experience of the hospital as reported to the agency.
12 Within 6 months after the end of each hospital fiscal year,
13 the agency shall certify the amount of the assessment for each
14 hospital. The assessment shall be payable to and collected by
15 the agency in equal quarterly amounts, on or before the first
16 day of each calendar quarter, beginning with the first full
17 calendar quarter that occurs after the agency certifies the
18 amount of the assessment for each hospital. All moneys
19 collected pursuant to this subsection shall be deposited into
20 the Public Medical Assistance Trust Fund.
21 (b) There is imposed upon each hospital an assessment
22 in an amount equal to 1 percent of the annual net operating
23 revenue for outpatient services for each hospital, such
24 revenue to be determined by the agency, based on the actual
25 experience of the hospital as reported to the agency. While
26 prior year report worksheets may be reconciled to the
27 hospital's audited financial statements, no additional audited
28 financial components may be required for the purposes of
29 determining the amount of the assessment imposed pursuant to
30 this section other than those in effect on July 1, 2000.
31 Within 6 months after the end of each hospital fiscal year,

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1 the agency shall certify the amount of the assessment for each
2 hospital. The assessment shall be payable to and collected by
3 the agency in equal quarterly amounts, on or before the first
4 day of each calendar quarter, beginning with the first full
5 calendar quarter that occurs after the agency certifies the
6 amount of the assessment for each hospital. All moneys
7 collected pursuant to this subsection shall be deposited into
8 the Public Medical Assistance Trust Fund.
9 (c) The reduced assessment on hospital outpatient
10 services contained in section 16 of chapter 2000-256, Laws of
11 Florida, shall be imposed upon the annual net operating
12 revenue for outpatient services for each hospital for each
13 hospital fiscal year beginning on or after July 1, 2000. For
14 each hospital fiscal year beginning before July 1, 2000, an
15 assessment in an amount equal to 1.5 percent, as required by
16 s. 395.701, Florida Statutes (2000), shall be imposed. This
17 paragraph clarifies the law as it has existed since July 1,
18 2000.
19 Section 4. Paragraph (b) of subsection (2) and
20 paragraph (d) of subsection (13) of section 409.908, Florida
21 Statutes, are amended to read:
22 409.908 Reimbursement of Medicaid providers.--Subject
23 to specific appropriations, the agency shall reimburse
24 Medicaid providers, in accordance with state and federal law,
25 according to methodologies set forth in the rules of the
26 agency and in policy manuals and handbooks incorporated by
27 reference therein. These methodologies may include fee
28 schedules, reimbursement methods based on cost reporting,
29 negotiated fees, competitive bidding pursuant to s. 287.057,
30 and other mechanisms the agency considers efficient and
31 effective for purchasing services or goods on behalf of

1 recipients. If a provider is reimbursed based on cost
2 reporting and submits a cost report late and that cost report
3 would have been used to set a lower reimbursement rate for a
4 rate semester, then the provider's rate for that semester
5 shall be retroactively calculated using the new cost report,
6 and full payment at the recalculated rate shall be effected
7 retroactively. Medicare-granted extensions for filing cost
8 reports, if applicable, shall also apply to Medicaid cost
9 reports. Payment for Medicaid compensable services made on
10 behalf of Medicaid eligible persons is subject to the
11 availability of moneys and any limitations or directions
12 provided for in the General Appropriations Act or chapter 216.
13 Further, nothing in this section shall be construed to prevent
14 or limit the agency from adjusting fees, reimbursement rates,
15 lengths of stay, number of visits, or number of services, or
16 making any other adjustments necessary to comply with the
17 availability of moneys and any limitations or directions
18 provided for in the General Appropriations Act, provided the
19 adjustment is consistent with legislative intent.
20 (2)
21 (b) Subject to any limitations or directions provided
22 for in the General Appropriations Act, the agency shall
23 establish and implement a Florida Title XIX Long-Term Care
24 Reimbursement Plan (Medicaid) for nursing home care in order
25 to provide care and services in conformance with the
26 applicable state and federal laws, rules, regulations, and
27 quality and safety standards and to ensure that individuals
28 eligible for medical assistance have reasonable geographic
29 access to such care.
30 ~~1. Changes of ownership or of licensed operator may or~~
31 ~~may not qualify for increases in reimbursement rates~~

~~associated with the change of ownership or of licensed operator. The agency may amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.~~

1.~~2.~~ The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care subcomponent of the per diem rate shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target.

2.~~3.~~ The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing administration, minimum data set, and care plan coordinators, staff development, and staffing coordinator.

3.~~4.~~ All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly

allocated to the direct care subcomponent from a home office or management company.

4.~~5.~~ On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

5.~~6.~~ In order to offset the cost of general and professional liability insurance, the agency shall amend the plan to allow for interim rate adjustments to reflect increases in the cost of general or professional liability insurance for nursing homes. This provision shall be implemented to the extent existing appropriations are available.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(13) Medicare premiums for persons eligible for both Medicare and Medicaid coverage shall be paid at the rates established by Title XVIII of the Social Security Act. For Medicare services rendered to Medicaid-eligible persons,

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1 Medicaid shall pay Medicare deductibles and coinsurance as
2 follows:
3 (d) Notwithstanding paragraphs (a)-(c):
4 1. Medicaid payments for Nursing Home Medicare part A
5 coinsurance shall be limited to ~~the lesser of the Medicare~~
6 ~~coinsurance amount or~~ the Medicaid nursing home per diem rate
7 less any amounts paid by Medicare, but only up to the amount
8 of Medicare coinsurance. The Medicaid per diem rate shall be
9 the rate in effect for the dates of service of the crossover
10 claims and may not be subsequently adjusted due to subsequent
11 per diem rate adjustments.
12 2. Medicaid shall pay all deductibles and coinsurance
13 for Medicare-eligible recipients receiving freestanding end
14 stage renal dialysis center services.
15 3. Medicaid payments for general hospital inpatient
16 services shall be limited to the Medicare deductible per spell
17 of illness. Medicaid shall make no payment toward coinsurance
18 for Medicare general hospital inpatient services.
19 4. Medicaid shall pay all deductibles and coinsurance
20 for Medicare emergency transportation services provided by
21 ambulances licensed pursuant to chapter 401.
22 Section 5. Paragraph (b) of subsection (4) of section
23 409.912, Florida Statutes, is amended to read:
24 409.912 Cost-effective purchasing of health care.--The
25 agency shall purchase goods and services for Medicaid
26 recipients in the most cost-effective manner consistent with
27 the delivery of quality medical care. To ensure that medical
28 services are effectively utilized, the agency may, in any
29 case, require a confirmation or second physician's opinion of
30 the correct diagnosis for purposes of authorizing future
31 services under the Medicaid program. This section does not

1 restrict access to emergency services or poststabilization
2 care services as defined in 42 C.F.R. part 438.114. Such
3 confirmation or second opinion shall be rendered in a manner
4 approved by the agency. The agency shall maximize the use of
5 prepaid per capita and prepaid aggregate fixed-sum basis
6 services when appropriate and other alternative service
7 delivery and reimbursement methodologies, including
8 competitive bidding pursuant to s. 287.057, designed to
9 facilitate the cost-effective purchase of a case-managed
10 continuum of care. The agency shall also require providers to
11 minimize the exposure of recipients to the need for acute
12 inpatient, custodial, and other institutional care and the
13 inappropriate or unnecessary use of high-cost services. The
14 agency shall contract with a vendor to monitor and evaluate
15 the clinical practice patterns of providers in order to
16 identify trends that are outside the normal practice patterns
17 of a provider's professional peers or the national guidelines
18 of a provider's professional association. The vendor must be
19 able to provide information and counseling to a provider whose
20 practice patterns are outside the norms, in consultation with
21 the agency, to improve patient care and reduce inappropriate
22 utilization. The agency may mandate prior authorization, drug
23 therapy management, or disease management participation for
24 certain populations of Medicaid beneficiaries, certain drug
25 classes, or particular drugs to prevent fraud, abuse, overuse,
26 and possible dangerous drug interactions. The Pharmaceutical
27 and Therapeutics Committee shall make recommendations to the
28 agency on drugs for which prior authorization is required. The
29 agency shall inform the Pharmaceutical and Therapeutics
30 Committee of its decisions regarding drugs subject to prior
31 authorization. The agency is authorized to limit the entities

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1 it contracts with or enrolls as Medicaid providers by
2 developing a provider network through provider credentialing.
3 The agency may competitively bid single-source-provider
4 contracts if procurement of goods or services results in
5 demonstrated cost savings to the state without limiting access
6 to care. The agency may limit its network based on the
7 assessment of beneficiary access to care, provider
8 availability, provider quality standards, time and distance
9 standards for access to care, the cultural competence of the
10 provider network, demographic characteristics of Medicaid
11 beneficiaries, practice and provider-to-beneficiary standards,
12 appointment wait times, beneficiary use of services, provider
13 turnover, provider profiling, provider licensure history,
14 previous program integrity investigations and findings, peer
15 review, provider Medicaid policy and billing compliance
16 records, clinical and medical record audits, and other
17 factors. Providers shall not be entitled to enrollment in the
18 Medicaid provider network. The agency shall determine
19 instances in which allowing Medicaid beneficiaries to purchase
20 durable medical equipment and other goods is less expensive to
21 the Medicaid program than long-term rental of the equipment or
22 goods. The agency may establish rules to facilitate purchases
23 in lieu of long-term rentals in order to protect against fraud
24 and abuse in the Medicaid program as defined in s. 409.913.
25 The agency may seek federal waivers necessary to administer
26 these policies.
27 (4) The agency may contract with:
28 (b) An entity that is providing comprehensive
29 behavioral health care services to certain Medicaid recipients
30 through a capitated, prepaid arrangement pursuant to the
31 federal waiver provided for by s. 409.905(5). Such an entity

1 must be licensed under chapter 624, chapter 636, or chapter
2 641 and must possess the clinical systems and operational
3 competence to manage risk and provide comprehensive behavioral
4 health care to Medicaid recipients. As used in this paragraph,
5 the term "comprehensive behavioral health care services" means
6 covered mental health and substance abuse treatment services
7 that are available to Medicaid recipients. The secretary of
8 the Department of Children and Family Services shall approve
9 provisions of procurements related to children in the
10 department's care or custody prior to enrolling such children
11 in a prepaid behavioral health plan. Any contract awarded
12 under this paragraph must be competitively procured. In
13 developing the behavioral health care prepaid plan procurement
14 document, the agency shall ensure that the procurement
15 document requires the contractor to develop and implement a
16 plan to ensure compliance with s. 394.4574 related to services
17 provided to residents of licensed assisted living facilities
18 that hold a limited mental health license. Except as provided
19 in subparagraph 8., and except in counties where the Medicaid
20 managed care pilot program is authorized pursuant to s.
21 409.91211, the agency shall seek federal approval to contract
22 with a single entity meeting these requirements to provide
23 comprehensive behavioral health care services to all Medicaid
24 recipients not enrolled in a Medicaid managed care plan
25 authorized under s. 409.91211 or a Medicaid health maintenance
26 organization in an AHCA area. In an AHCA area where the
27 Medicaid managed care pilot program is authorized pursuant to
28 s. 409.91211 in one or more counties, the agency may procure a
29 contract with a single entity to serve the remaining counties
30 as an AHCA area or the remaining counties may be included with
31 an adjacent AHCA area and shall be subject to this paragraph.

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1 Each entity must offer sufficient choice of providers in its
2 network to ensure recipient access to care and the opportunity
3 to select a provider with whom they are satisfied. The network
4 shall include all public mental health hospitals. To ensure
5 unimpaired access to behavioral health care services by
6 Medicaid recipients, all contracts issued pursuant to this
7 paragraph shall require 80 percent of the capitation paid to
8 the managed care plan, including health maintenance
9 organizations, to be expended for the provision of behavioral
10 health care services. In the event the managed care plan
11 expends less than 80 percent of the capitation paid pursuant
12 to this paragraph for the provision of behavioral health care
13 services, the difference shall be returned to the agency. The
14 agency shall provide the managed care plan with a
15 certification letter indicating the amount of capitation paid
16 during each calendar year for the provision of behavioral
17 health care services pursuant to this section. The agency may
18 reimburse for substance abuse treatment services on a
19 fee-for-service basis until the agency finds that adequate
20 funds are available for capitated, prepaid arrangements.
21 1. By January 1, 2001, the agency shall modify the
22 contracts with the entities providing comprehensive inpatient
23 and outpatient mental health care services to Medicaid
24 recipients in Hillsborough, Highlands, Hardee, Manatee, and
25 Polk Counties, to include substance abuse treatment services.
26 2. By July 1, 2003, the agency and the Department of
27 Children and Family Services shall execute a written agreement
28 that requires collaboration and joint development of all
29 policy, budgets, procurement documents, contracts, and
30 monitoring plans that have an impact on the state and Medicaid
31 community mental health and targeted case management programs.

1 3. Except as provided in subparagraph 8., by July 1,
2 2006, the agency and the Department of Children and Family
3 Services shall contract with managed care entities in each
4 AHCA area except area 6 or arrange to provide comprehensive
5 inpatient and outpatient mental health and substance abuse
6 services through capitated prepaid arrangements to all
7 Medicaid recipients who are eligible to participate in such
8 plans under federal law and regulation. In AHCA areas where
9 eligible individuals number less than 150,000, the agency
10 shall contract with a single managed care plan to provide
11 comprehensive behavioral health services to all recipients who
12 are not enrolled in a Medicaid health maintenance organization
13 or a Medicaid capitated managed care plan authorized under s.
14 409.91211. The agency may contract with more than one
15 comprehensive behavioral health provider to provide care to
16 recipients who are not enrolled in a Medicaid capitated
17 managed care plan authorized under s. 409.91211 or a Medicaid
18 health maintenance organization in AHCA areas where the
19 eligible population exceeds 150,000. In an AHCA area where the
20 Medicaid managed care pilot program is authorized pursuant to
21 s. 409.91211 in one or more counties, the agency may procure a
22 contract with a single entity to serve the remaining counties
23 as an AHCA area or the remaining counties may be included with
24 an adjacent AHCA area and shall be subject to this paragraph.
25 Contracts for comprehensive behavioral health providers
26 awarded pursuant to this section shall be competitively
27 procured. Both for-profit and not-for-profit corporations
28 shall be eligible to compete. Managed care plans contracting
29 with the agency under subsection (3) shall provide and receive
30 payment for the same comprehensive behavioral health benefits
31 as provided in AHCA rules, including handbooks incorporated by

1 reference. In AHCA area 11, the agency shall contract with at
2 least two comprehensive behavioral health care providers to
3 provide behavioral health care to recipients in that area who
4 are enrolled in, or assigned to, the MediPass program. One of
5 the behavioral health care contracts shall be with the
6 existing provider service network pilot project, as described
7 in paragraph (d), for the purpose of demonstrating the
8 cost-effectiveness of the provision of quality mental health
9 services through a public hospital-operated managed care
10 model. Payment shall be at an agreed-upon capitated rate to
11 ensure cost savings. Of the recipients in area 11 who are
12 assigned to MediPass under the provisions of s.
13 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled
14 recipients shall be assigned to the existing provider service
15 network in area 11 for their behavioral care.
16 4. By October 1, 2003, the agency and the department
17 shall submit a plan to the Governor, the President of the
18 Senate, and the Speaker of the House of Representatives which
19 provides for the full implementation of capitated prepaid
20 behavioral health care in all areas of the state.
21 a. Implementation shall begin in 2003 in those AHCA
22 areas of the state where the agency is able to establish
23 sufficient capitation rates.
24 b. If the agency determines that the proposed
25 capitation rate in any area is insufficient to provide
26 appropriate services, the agency may adjust the capitation
27 rate to ensure that care will be available. The agency and the
28 department may use existing general revenue to address any
29 additional required match but may not over-obligate existing
30 funds on an annualized basis.
31

1 c. Subject to any limitations provided for in the
2 General Appropriations Act, the agency, in compliance with
3 appropriate federal authorization, shall develop policies and
4 procedures that allow for certification of local and state
5 funds.
6 5. Children residing in a statewide inpatient
7 psychiatric program, or in a Department of Juvenile Justice or
8 a Department of Children and Family Services residential
9 program approved as a Medicaid behavioral health overlay
10 services provider shall not be included in a behavioral health
11 care prepaid health plan or any other Medicaid managed care
12 plan pursuant to this paragraph.
13 6. In converting to a prepaid system of delivery, the
14 agency shall in its procurement document require an entity
15 providing only comprehensive behavioral health care services
16 to prevent the displacement of indigent care patients by
17 enrollees in the Medicaid prepaid health plan providing
18 behavioral health care services from facilities receiving
19 state funding to provide indigent behavioral health care, to
20 facilities licensed under chapter 395 which do not receive
21 state funding for indigent behavioral health care, or
22 reimburse the unsubsidized facility for the cost of behavioral
23 health care provided to the displaced indigent care patient.
24 7. Traditional community mental health providers under
25 contract with the Department of Children and Family Services
26 pursuant to part IV of chapter 394, child welfare providers
27 under contract with the Department of Children and Family
28 Services in areas 1 and 6, and inpatient mental health
29 providers licensed pursuant to chapter 395 must be offered an
30 opportunity to accept or decline a contract to participate in
31 any provider network for prepaid behavioral health services.

1 8. For fiscal year 2004-2005, all Medicaid eligible
2 children, except children in areas 1 and 6, whose cases are
3 open for child welfare services in the HomeSafeNet system,
4 shall be enrolled in MediPass or in Medicaid fee-for-service
5 and all their behavioral health care services including
6 inpatient, outpatient psychiatric, community mental health,
7 and case management shall be reimbursed on a fee-for-service
8 basis. Beginning July 1, 2005, such children, who are open for
9 child welfare services in the HomeSafeNet system, shall
10 receive their behavioral health care services through a
11 specialty prepaid plan operated by community-based lead
12 agencies either through a single agency or formal agreements
13 among several agencies. The specialty prepaid plan must result
14 in savings to the state comparable to savings achieved in
15 other Medicaid managed care and prepaid programs. Such plan
16 must provide mechanisms to maximize state and local revenues.
17 The specialty prepaid plan shall be developed by the agency
18 and the Department of Children and Family Services. The agency
19 is authorized to seek any federal waivers to implement this
20 initiative. Medicaid-eligible children whose cases are open
21 for child welfare services in the HomeSafeNet system and who
22 reside in AHCA area 10 are exempt from the specialty prepaid
23 plan upon the development of a service delivery mechanism for
24 children who reside in area 10 as specified in s.
25 409.91211(3)(dd).
26 Section 6. Subsection (13) of section 409.9122,
27 Florida Statutes, is amended to read:
28 409.9122 Mandatory Medicaid managed care enrollment;
29 programs and procedures.--
30 (13) Effective July 1, 2003, the agency shall adjust
31 the enrollee assignment process of Medicaid managed prepaid

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1 health plans for those Medicaid managed prepaid plans
2 operating in Miami-Dade County which have executed a contract
3 with the agency for a minimum of 8 consecutive years in order
4 for the Medicaid managed prepaid plan to maintain a minimum
5 enrollment level of 15,000 members per month. <u>When assigning</u>
6 <u>enrollees pursuant to this subsection, the agency shall give</u>
7 <u>priority to providers that initially qualified under this</u>
8 <u>subsection until such providers reach and maintain an</u>
9 <u>enrollment level of 15,000 members per month. A prepaid health</u>
10 <u>plan that has a statewide Medicaid enrollment of 25,000 or</u>
11 <u>more members is not eligible for enrollee assignments under</u>
12 <u>this subsection.</u>
13 Section 7. Effective March 1, 2008, paragraph (k) of
14 subsection (2) of section 409.9122, Florida Statutes, is
15 amended to read:
16 409.9122 Mandatory Medicaid managed care enrollment;
17 programs and procedures.--
18 (2)
19 (k) When a Medicaid recipient does not choose a
20 managed care plan or MediPass provider, the agency shall
21 assign the Medicaid recipient to a managed care plan, except
22 in those counties in which there are fewer than two managed
23 care plans accepting Medicaid enrollees, in which case
24 assignment shall be to a managed care plan or a MediPass
25 provider. Medicaid recipients in counties with fewer than two
26 managed care plans accepting Medicaid enrollees who are
27 subject to mandatory assignment but who fail to make a choice
28 shall be assigned to managed care plans until an enrollment of
29 35 percent in MediPass and 65 percent in managed care plans,
30 of all those eligible to choose managed care, is achieved.
31 Once that enrollment is achieved, the assignments shall be

divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. ~~In service areas 1 and 6 of the Agency for Health Care Administration where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan.~~ For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.

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Section 8. Paragraph (dd) of subsection (3) of section 409.91211, Florida Statutes, is amended to read:

409.91211 Medicaid managed care pilot program.--

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(dd) To implement ~~develop and recommend~~ service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system ~~in foster care~~. These services must be coordinated with community-based care providers as specified in s. 409.1671 ~~s. 409.1675~~, where available, and be sufficient to meet the medical, developmental, behavioral, and emotional needs of these children. These service delivery mechanisms must be implemented no later than July 1, 2008, in AHCA area 10 in order for the children in AHCA area 10 to remain exempt from the statewide plan under s. 409.912(4)(b)8.

Section 9. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

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