CHAMBER ACTION

The Committee on Future of Florida's Families recommends the following:

Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to behavioral health; amending s. 20.19, F.S.; requiring the Secretary of Children and Family Services to appoint an assistant secretary for behavioral health; providing responsibilities of the assistant secretary; providing for the appointment of a Director of Mental Health Services; providing duties of the director; providing for the appointment of a Director of Substance Abuse Services; providing duties of the director; creating s. 394.655, F.S.; providing for the establishment of the Behavioral Health Advisory Board; providing membership of the advisory board; providing duties of the advisory board; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to seek federal approval to contract with a single entity to provide comprehensive behavioral health care services to Medicaid recipients; requiring the agency to submit a plan for fully implementing capitated prepaid behavioral health care in

all regions of the state; providing for implementation of the plan; authorizing the agency to adjust the capitation rate under specified circumstances; requiring the agency to develop policies and procedures that allow for certification of local funds; requiring the agency to implement new Medicaid procedure codes for specified services; providing a requirement with respect to the match requirements for such procedure codes; requiring the Department of Children and Family Services to impose specified requirements on its contractors in order to certify local funds; authorizing the capping of local and state mental health and substance abuse dollars certified as state Medicaid match; providing for reduction of certification of such funds under specified circumstances; authorizing the agency to conduct a review of a local provider who has applied to enroll as a Medicaid provider under the certified match program; providing responsibility of the department notwithstanding the finding of a review; requiring the agency to develop a reimbursement schedule specific to a local provider's certified match program based on the federal rehabilitative services option; requiring the agency and the local provider to provide specified information and documents to the Medicaid Fraud Control Unit of the Department of Legal Affairs upon request; amending s. 394.741, F.S.; revising and providing additional accreditation requirements for providers of behavioral health care services; amending s. 394.9082, F.S.;

authorizing the department to contract with a single managing entity or provider network for the delivery of state-funded mental health services; requiring the managing entity to coordinate its delivery of mental health and substance abuse services with all prepaid mental health plans in the region or the district; providing contract requirements; correcting cross references; amending s. 636.066, F.S.; providing that payments made to a prepaid limited health services organization by the Agency for Health Care Administration under a contract to provide comprehensive behavioral health care services to Medicaid recipients are not subject to the insurance premium tax; requiring the agency to provide the prepaid limited health services organization with a specified certification letter; amending s. 641.47, F.S.; expanding the definition of "emergency medical condition" to include a specified psychiatric condition; amending ss. 409.908, 409.91196, 409.9122, 636.0145, 641.225, and 641.386, F.S.; correcting cross references; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (2) of section 20.19, Florida Statutes, is amended to read:

20.19 Department of Children and Family Services.--There is created a Department of Children and Family Services.

(2) SECRETARY OF CHILDREN AND FAMILY SERVICES; DEPUTY SECRETARY.--

(a) The head of the department is the Secretary of Children and Family Services. The secretary is appointed by the Governor, subject to confirmation by the Senate. The secretary serves at the pleasure of the Governor.

(b) The secretary shall appoint a deputy secretary who shall act in the absence of the secretary. The deputy secretary is directly responsible to the secretary, performs such duties as are assigned by the secretary, and serves at the pleasure of the secretary.

(c) The secretary shall appoint an assistant secretary for behavioral health services to manage behavioral health services. The assistant secretary for behavioral health services shall have responsibility and authority for all of the programs, services, functions, and duties included in chapters 394 and 397.

1. The secretary shall appoint a Director of Mental Health Services and a Director of Substance Abuse Services.

2. The Director of Mental Health Services shall directly administer all mental health programs, staff, budgets, duties, and functions of the mental health program and shall be responsible to the assistant secretary for behavioral health services; the Director of Substance Abuse Services shall directly administer all of the programs, staff, budgets, duties, and functions of the substance abuse program and shall be responsible to the assistant secretary for behavioral health services.

3. The assistant secretary shall serve at the pleasure of the secretary.

(d) The secretary shall appoint the directors or executive directors of any commission or council assigned to the department. Directors and executive directors shall serve at the pleasure of the secretary as provided for division directors in s. 110.205.

(e)~~(c)~~ The secretary has the authority and responsibility to ensure that the mission of the department is fulfilled in accordance with state and federal laws, rules, and regulations.

Section 2. Section 394.655, Florida Statutes, is created to read:

394.655 Behavioral Health Advisory Board; powers and duties; composition.--

(1) The Behavioral Health Advisory Board shall be comprised of 11 members. Each member shall be appointed for a 2-year term. No member shall be reappointed for more than two subsequent terms. Five members shall be appointed by the Governor, three members shall be appointed by the President of the Senate, and three members shall be appointed by the Speaker of the House of Representatives.

(a) Of the five members appointed by the Governor, four must be prominent community leaders, two of whom have experience and interest in substance abuse, and two of whom have experience and interest in mental health.

(b) Of the three members appointed by the President of the Senate, one must be a consumer of publicly-funded mental health services or the family member of a consumer, one must be an

expert in elder mental health, and one must be an expert in elder substance abuse.

(c) Of the three members appointed by the Speaker of the House of Representatives, one must represent the judiciary or criminal justice system, one must have expertise in child welfare, and one must have expertise in bio-ethics.

(2) The director of the Medicaid program and the secretary of the Department of Elder Affairs shall serve as ex officio members of the advisory board.

(3) Members of the advisory board shall serve without compensation, but are entitled to reimbursement for travel and per diem expenses pursuant to s. 112.061.

(4) Persons who derive their income from resources controlled by the Department of Children and Family Services or the Agency for Health Care Administration are ineligible for membership on the advisory board.

(5) The advisory board shall prepare the behavioral health budget request and the secretary shall submit the budget request to the Governor.

(6) The advisory board shall work with the Assistant Secretary of Behavioral Health to ensure that the behavioral health care needs as identified in local needs assessments and plans are met. The board shall work to enhance the understanding of all persons of the efficacy of behavioral health services and work to ensure that adequate resources are available.

Section 3. Subsections (1) and (2) of section 409.912, Florida Statutes, are renumbered as subsections (2) and (3), respectively, subsection (3) is renumbered as subsection (4) and

paragraphs (b) and (c) of said subsection are amended, subsection (19) is renumbered as subsection (22) and paragraph (c) of said subsection is amended, subsection (27) is renumbered as subsection (30) and amended, present subsections (4) through (18) are renumbered as subsections (7) through (21), respectively, present subsections (20) through (26) are renumbered as subsections (23) through (29), respectively, present subsections (28) through (40) are renumbered as subsections (31) through (43), respectively, and new subsections (1), (5), and (6) are added to said section, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may establish prior authorization requirements for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior

authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization.

(1) The agency shall work with the Department of Children and Family Services to ensure access of children and families in the child protection system to needed and appropriate mental health and substance abuse services.

(4)~~(3)~~ The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The Secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living

facilities that hold a limited mental health license. The agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients in a group of districts or counties. Each entity must offer sufficient choices of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom the recipient is satisfied. ~~The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services.~~ To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance-abuse-treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient

and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance-abuse-treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policies, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. By October 1, 2003, the agency shall submit a plan to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the chairs of the relevant substantive committees of the Senate and the House of Representatives for review and approval that provides for fully implementing capitated prepaid behavioral health care in all regions of the state.

a. Implementation shall begin in 2003 in those areas of the state where the agency is able to establish a sound capitation rate.

b. If the agency determines that the proposed capitation rate is insufficient to attract providers or claims data does not provide sufficient information for the development of an actuarially sound rate, the agency may adjust the capitation rate to ensure that care will be available.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local funds.

~~2. By December 31, 2001, the agency shall contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Charlotte, Collier, DeSoto, Escambia, Glades, Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota, and Walton Counties. The agency may contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Alachua County. The agency may determine if Sarasota County shall be included as a separate catchment area or included in any other agency geographic area.~~

4.~~3.~~ Children residing in a Department of Juvenile Justice residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan pursuant to this paragraph.

5.~~4.~~ In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

6.~~5.~~ Traditional community mental health providers under contract with the Department of Children and Family Services

pursuant to part IV of chapter 394 and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (17)~~(14)~~ and (18)~~(15)~~.

(5) By October 1, 2003, the agency shall implement new Medicaid procedure codes to the extent feasible, for emergency and crisis care, supportive residential services, and other services designed to maximize the use of Medicaid funds for Medicaid eligible recipients. The agency shall include in the agreement developed pursuant to subsection (4) a provision that ensures that the match requirements for these new procedure codes are met by certifying eligible general revenue or local funds that are currently expended on these services by the department with contracted alcohol, drug abuse, and mental health providers.

(6) To certify local funds, the Department of Children and Family Services shall require its contractors to verify the

Medicaid eligibility of each recipient served; develop and maintain the financial and individual service plan records needed to document the appropriate use of state and federal Medicaid funds; comply with all state and federal Medicaid laws, rules, regulations, and policies, including, but not limited to, those related to the confidentiality of records and freedom of choice of providers; and be responsible for reimbursing the cost of any state or federal disallowance that results from failure to comply with state or federal Medicaid laws, rules, or regulations.

(a) Local and state mental health and substance abuse dollars certified as state Medicaid match may be capped based on the maximum amount of federal participation budgeted for this purpose. Unless otherwise specifically provided for in the General Appropriations Act, certification of such funds shall be reduced proportionately to other voluntary Medicaid programs if a cap is established by the federal Medicaid agency that reduces federal Medicaid funding.

(b) Within 90 days after a local provider applies to enroll as a Medicaid provider under the certified match program, the agency may conduct a review to ensure that the provider has the capability to comply with the requirements of this subsection. A finding by the agency that a provider has the capability to comply with the requirements of paragraph (a) shall not relieve the Department of Children and Family Services of its responsibility for correcting any deficiencies or for reimbursing the cost of the state or federal disallowances identified pursuant to any subsequent state or federal audits.

(c) The agency shall develop a reimbursement schedule specific to the local provider's certified match program which is based on the federal rehabilitative services option.

(d) The confidentiality of any information or documents relating to this section held by the agency or the local provider is waived and the agency and the local provider shall provide any information or documents relating to this section to the Medicaid Fraud Control Unit of the Department of Legal Affairs upon request and pursuant to its authority under s. 409.920.

(19) Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (24)~~(21)~~.

(27) The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (21)~~(18)~~(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its

agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract.

Section 4. Subsection (6) of section 394.741, Florida Statutes, is amended, a new subsection (7) is added to said section, and subsections (7) and (8) are renumbered as subsections (8) and (9), respectively, to read:

394.741 Accreditation requirements for providers of behavioral health care services.--

(6) The department or agency, by accepting the survey or inspection of an accrediting organization, does not forfeit its rights to perform inspections at any time, including contract monitoring to ensure that services that have been billed ~~deliverables~~ are provided in accordance with the contract.

(7) In monitoring the financial operations of its contractors, the department shall perform an off-site desk review of its contractors' most recent audit conducted by an

independent certified public accountant and only conduct on-site monitoring of problems identified by such audit.

(8)~~(7)~~ The department and the agency shall report to the Legislature by January 1, 2003, on the viability of mandating all organizations under contract with the department for the provision of behavioral health care services, or licensed by the agency or department to be accredited. The department and the agency shall also report to the Legislature by January 1, 2003, on the viability of privatizing all licensure and monitoring functions through an accrediting organization.

(9)~~(8)~~ The accreditation requirements of this section shall apply to contracted organizations that are already accredited immediately upon becoming law.

Section 5. Paragraphs (a), (b), and (e) of subsection (4) and subsection (5) of section 394.9082, Florida Statutes, are amended to read:

394.9082 Behavioral health service delivery strategies.--

(4) CONTRACT FOR SERVICES.--

(a) The Department of Children and Family Services and the Agency for Health Care Administration may contract for the provision or management of behavioral health services with a managing entity in at least two geographic areas. Both the Department of Children and Family Services and the Agency for Health Care Administration must contract with the same managing entity in any distinct geographic area where the strategy operates. This managing entity shall be accountable for the delivery of behavioral health services specified by the department and the agency for children, adolescents, and adults.

The geographic area must be of sufficient size in population and have enough public funds for behavioral health services to allow for flexibility and maximum efficiency. Notwithstanding the provisions of s. 409.912(4)~~(3)~~(b)1. ~~and 2.~~, at least one service delivery strategy must be in one of the service districts in the catchment area of G. Pierce Wood Memorial Hospital.

(b) Under one of the service delivery strategies, the Department of Children and Family Services may contract with a prepaid mental health plan that operates under s. 409.912 to be the managing entity. Under this strategy, the Department of Children and Family Services is not required to competitively procure those services and, notwithstanding other provisions of law, may employ prospective payment methodologies that the department finds are necessary to improve client care or institute more efficient practices. The Department of Children and Family Services may employ in its contract any provision of the current prepaid behavioral health care plan authorized under s. 409.912(4)~~(3)~~(a) and (b), or any other provision necessary to improve quality, access, continuity, and price. Any contracts under this strategy in Area 6 of the Agency for Health Care Administration or in the prototype region under s. 20.19(7) of the Department of Children and Family Services may be entered with the existing substance abuse treatment provider network if an administrative services organization is part of its network. In Area 6 of the Agency for Health Care Administration or in the prototype region of the Department of Children and Family Services, the Department of Children and Family Services and the Agency for Health Care Administration may employ alternative

service delivery and financing methodologies, which may include prospective payment for certain population groups. The population groups that are to be provided these substance abuse services would include at a minimum: individuals and families receiving family safety services; Medicaid-eligible children, adolescents, and adults who are substance-abuse-impaired; or current recipients and persons at risk of needing cash assistance under Florida's welfare reform initiatives.

(e) The cost of the managing entity contract shall be funded through a combination of funds from the Department of Children and Family Services and the Agency for Health Care Administration. To operate the managing entity, the Department of Children and Family Services and the Agency for Health Care Administration may not expend more than 10 percent of the annual appropriations for mental health and substance abuse treatment services prorated to the geographic areas and must include all behavioral health Medicaid funds, including psychiatric inpatient funds. This restriction does not apply to a prepaid behavioral health plan that is authorized under s. 409.912(4)~~(3)~~(a) and (b).

(5) STATEWIDE ACTIONS.--~~If Medicaid appropriations for Community Mental Health Services or Mental Health Targeted Case Management are reduced in fiscal year 2001-2002,~~ The agency and the department shall jointly develop and implement strategies that reduce service costs in a manner that mitigates the impact on persons in need of those services. The agency and department may employ any methodologies on a regional or statewide basis necessary to achieve the reduction, including but not limited to

use of case rates, prepaid per capita contracts, utilization management, expanded use of care management, use of waivers from the Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~ to maximize federal matching of current local and state funding, modification or creation of additional procedure codes, and certification of match or other management techniques. The department may contract with a single managing entity or provider network that shall be responsible for delivering state-funded mental health services. The managing entity shall coordinate its delivery of mental health and substance abuse services with all prepaid mental health plans in the region or the district. The department may include in its contract with the managing entity data management and data reporting requirements, and clinical, program management, and administrative functions. Before the department contracts for these functions with the provider network, the department shall determine that the entity has the capacity and capability to assume these functions. The roles and responsibilities of each party must be clearly delineated in the contract.

Section 6. Subsection (2) of section 636.066, Florida Statutes, is amended to read:

636.066 Taxes imposed.--

(2) Beginning January 1, 1994, the tax shall be imposed on all premiums, contributions, and assessments for limited health services. Payments made to a prepaid limited health services organization by the Agency for Health Care Administration under a contract entered into pursuant to s. 409.912(4)(b) for comprehensive behavioral health care services that specifies a

minimum loss ratio do not constitute premiums, contributions, or assessments for limited health services and are not subject to the premium tax under s. 624.509. The Agency for Health Care Administration shall provide the prepaid limited health services organization with a certification letter indicating the amount of premiums, capitation, and assessments it has paid during each calendar year for such comprehensive behavioral health services.

Section 7. Subsection (7) of section 641.47, Florida Statutes, is amended to read:

641.47 Definitions.--As used in this part, the term:

(7) “Emergency medical condition” means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(c) A psychiatric condition manifested by acute symptoms of psychiatric disturbance or substance abuse by a person in a designated receiving facility under a court ex parte order for examination or placed by an authorized party for involuntary examination in accordance with s. 394.463.

Section 8. Subsection (4) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be affected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and, beginning September 1, 1995, shall include age-band differentials in such calculations. Effective July 1, 2001, the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals from reimbursement ceilings and the cost of special Medicaid payments shall not be included in premiums paid to health maintenance organizations or prepaid health care plans. Each rate semester, the agency shall calculate and publish a Medicaid hospital rate schedule that does not reflect either special Medicaid payments or the elimination of rate reimbursement ceilings, to be used by hospitals and Medicaid

health maintenance organizations, in order to determine the Medicaid rate referred to in ss. 409.912(20)~~(17)~~, 409.9128(5), and 641.513(6).

Section 9. Subsections (1) and (2) of section 409.91196, Florida Statutes, are amended to read:

409.91196 Supplemental rebate agreements; confidentiality of records and meetings.--

(1) Trade secrets, rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebates which are contained in records of the Agency for Health Care Administration and its agents with respect to supplemental rebate negotiations and which are prepared pursuant to a supplemental rebate agreement under s. 409.912(40)~~(37)~~(a)7. are confidential and exempt from s. 119.07 and s. 24(a), Art. I of the State Constitution.

(2) Those portions of meetings of the Medicaid Pharmaceutical and Therapeutics Committee at which trade secrets, rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebates are disclosed for discussion or negotiation of a supplemental rebate agreement under s. 409.912(40)~~(37)~~(a)7. are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

Section 10. Paragraph (f) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.--

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 45 percent in MediPass and 55 percent in managed care plans is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 45 percent and 55 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(4)~~(3)~~(g), Children's Medical Services network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes

health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. Beginning July 1, 2002, the agency shall assign all children in families who have not made a choice of a managed care plan or MediPass in the required timeframe to a pediatric emergency room diversion program described in s. 409.912(4)~~(3)~~(g) that, as of July 1, 2002, has executed a contract with the agency, until such network or program has reached an enrollment of 15,000 children. Once that minimum enrollment level has been reached, the agency shall assign children who have not chosen a managed care plan or MediPass to the network or program in a manner that maintains the minimum enrollment in the network or program at not less than 15,000 children. To the extent practicable, the agency shall also assign all eligible children in the same family to such network or program. 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.

Section 11. Section 636.0145, Florida Statutes, is amended to read:

636.0145 Certain entities contracting with Medicaid.--Notwithstanding the requirements of s. 409.912(4)~~(3)~~(b), an entity that is providing comprehensive inpatient and outpatient mental health care services to certain Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties through a capitated, prepaid arrangement pursuant to the federal waiver provided for in s. 409.905(5) must become licensed under chapter 636 by December 31, 1998. Any entity licensed under this chapter which provides services solely to Medicaid recipients under a contract with Medicaid shall be exempt from ss. 636.017, 636.018, 636.022, 636.028, and 636.034.

Section 12. Subsection (3) of section 641.225, Florida Statutes, is amended to read:

641.225 Surplus requirements.--

(3)(a) An entity providing prepaid capitated services which is authorized under s. 409.912(4)~~(3)~~(a) and which applies for a certificate of authority is subject to the minimum surplus requirements set forth in subsection (1), unless the entity is backed by the full faith and credit of the county in which it is located.

(b) An entity providing prepaid capitated services which is authorized under s. 409.912(4)~~(3)~~(b) or (c), and which applies for a certificate of authority is subject to the minimum surplus requirements set forth in s. 409.912.

Section 13. Subsection (4) of section 641.386, Florida Statutes, is amended to read:

641.386 Agent licensing and appointment required; exceptions.--

(4) All agents and health maintenance organizations shall comply with and be subject to the applicable provisions of ss. 641.309 and 409.912(22)~~(19)~~, and all companies and entities appointing agents shall comply with s. 626.451, when marketing for any health maintenance organization licensed pursuant to this part, including those organizations under contract with the Agency for Health Care Administration to provide health care services to Medicaid recipients or any private entity providing health care services to Medicaid recipients pursuant to a prepaid health plan contract with the Agency for Health Care Administration.

Section 14. This act shall take effect upon becoming a law.