1 CHAMBER ACTION
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6 The Committee on Appropriations recommends the following:
7
8 **Committee Substitute**
9 Remove the entire bill and insert:
10 A bill to be entitled
11 An act relating to behavioral health; amending s. 20.19,
12 F.S.; requiring the Secretary of Children and Family
13 Services to appoint an assistant secretary for behavioral
14 health services; providing responsibilities of the
15 assistant secretary; providing for the appointment of a
16 Director of Mental Health Services; providing duties of
17 the director; providing for the appointment of a Director
18 of Substance Abuse Services; providing duties of the
19 director; creating s. 394.655, F.S.; providing for the
20 establishment of the Behavioral Health Services Board;
21 providing membership of the board; providing for powers
22 and duties and responsibilities of the board; providing
23 for an annual evaluation and report; providing for an
24 independent evaluation of substance abuse and mental
25 health programs by the Office of Program Policy Analysis
26 and Government Accountability and the Auditor General;
27 requiring a report; providing for the expiration of the
28 board; amending s. 409.912, F.S.; requiring the Agency for

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29 Health Care Administration to seek federal approval to
30 contract with a single entity to provide comprehensive
31 behavioral health care services to Medicaid recipients;
32 requiring the agency and the Department of Children and
33 Family Services to execute a written agreement by a
34 specified date; requiring the agency to contract with
35 specified managed care entities to provide comprehensive
36 inpatient and outpatient mental health and substance abuse
37 services through capitated prepaid arrangements to
38 Medicaid recipients; providing requirements with respect
39 to such contracts; requiring the agency to submit a plan
40 for the full implementation of capitated prepaid
41 behavioral health care in all areas of the state;
42 providing plan requirements; excluding children residing
43 in specified residential programs of the Department of
44 Children and Family Services from the behavioral health
45 care prepaid health plan; allowing child welfare providers
46 to participate in the network for prepaid behavioral
47 health services; requiring the agency and the department
48 to develop a plan for implementing new Medicaid procedure
49 codes for specified services; providing plan requirements;
50 requiring approval of the plan by the Legislative Budget
51 Commission prior to implementation; amending s. 394.741,
52 F.S.; providing rights of the department and the agency to
53 monitor for a specified purpose; providing authority of
54 the department with respect to investigation of complaints
55 and monitoring of providers' compliance; requiring the
56 department to file a State Projects Compliance Supplement

57 for behavioral health care services; providing
58 requirements with respect to the monitoring of financial
59 operations of contractors; amending s. 394.9082, F.S.;
60 authorizing the department to contract with a single
61 managing entity or provider network for the delivery of
62 state-funded mental health services; requiring the
63 managing entity to coordinate its delivery of mental
64 health and substance abuse services with all prepaid
65 mental health plans in the region or the district;
66 providing contract requirements; correcting cross
67 references; amending s. 636.066, F.S.; providing that
68 payments made to a prepaid limited health services
69 organization by the Agency for Health Care Administration
70 under a contract to provide comprehensive behavioral
71 health care services to Medicaid recipients are not
72 subject to the insurance premium tax; requiring the agency
73 to provide the prepaid limited health services
74 organization with a specified certification letter;
75 amending ss. 409.908, 409.91196, 409.9122, 636.0145,
76 641.225, and 641.386, F.S.; correcting cross references;
77 providing an effective date.
78
79 Be It Enacted by the Legislature of the State of Florida:
80
81 Section 1. Subsection (2) of section 20.19, Florida
82 Statutes, is amended to read:
83 20.19 Department of Children and Family Services.--There
84 is created a Department of Children and Family Services.

85 (2) SECRETARY OF CHILDREN AND FAMILY SERVICES; DEPUTY
86 SECRETARY.--
87 (a) The head of the department is the Secretary of
88 Children and Family Services. The secretary is appointed by the
89 Governor, subject to confirmation by the Senate. The secretary
90 serves at the pleasure of the Governor.
91 (b) The secretary shall appoint a deputy secretary who
92 shall act in the absence of the secretary. The deputy secretary
93 is directly responsible to the secretary, performs such duties
94 as are assigned by the secretary, and serves at the pleasure of
95 the secretary.
96 (c) The secretary shall appoint an assistant secretary for
97 behavioral health services to manage behavioral health services.
98 The assistant secretary for behavioral health services shall
99 have responsibility and authority for all of the programs,
100 services, functions, and duties included in chapters 394 and
101 397.
102 1. The secretary shall appoint a Director of Mental Health
103 Services and a Director of Substance Abuse Services.
104 2. The Director of Mental Health Services shall directly
105 administer all mental health programs, staff, budgets, duties,
106 and functions of the mental health program and shall be
107 responsible to the assistant secretary for behavioral health
108 services; the Director of Substance Abuse Services shall
109 directly administer all of the programs, staff, budgets, duties,
110 and functions of the substance abuse program and shall be
111 responsible to the assistant secretary for behavioral health
112 services.

113 3. The assistant secretary shall serve at the pleasure of
114 the secretary.
115 (d) The secretary shall appoint the directors or executive
116 directors of any commission or council assigned to the
117 department. Directors and executive directors shall serve at the
118 pleasure of the secretary as provided for division directors in
119 s.
120 (e)~~(c)~~ The secretary has the authority and responsibility
121 to ensure that the mission of the department is fulfilled in
122 accordance with state and federal laws, rules, and regulations.
123 Section 2. Section 394.655, Florida Statutes, is created
124 to read:
125 394.655 Behavioral Health Services Board; powers and
126 duties; composition.--
127 (1) The Behavioral Health Services Board shall be
128 comprised of 11 members. Each member shall be appointed for a
129 2-year term. No member shall be reappointed for more than two
130 subsequent terms. Five members shall be appointed by the
131 Governor, three members shall be appointed by the President of
132 the Senate, and three members shall be appointed by the Speaker
133 of the House of Representatives.
134 (a) Of the five members appointed by the Governor, three
135 must be prominent community leaders with an interest in
136 substance abuse and two must be prominent community leaders with
137 an interest in mental health.
138 (b) Of the three members appointed by the President of the
139 Senate, one must be a consumer of publicly-funded mental health
140 services or a family member of a consumer, one must be a

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141 community leader who has an interest in substance abuse, and one
142 must be a community leader who an has interest in mental health.
143 (c) Of the three members appointed by the Speaker of the
144 House of Representatives, one must be a parent or a guardian of
145 a child receiving publicly-funded mental health or substance
146 abuse services and two shall be prominent community leaders, one
147 of whom is involved in the judiciary or criminal justice system
148 and one of whom is involved in child welfare community-based
149 care.
150 (2) The director of the Medicaid program, the Assistant
151 Secretary for Behavioral Health Services of the department, and
152 a representative of county government shall serve as ex officio
153 members of the board.
154 (3) Members of the board shall serve without compensation
155 but are entitled to reimbursement for travel and per diem
156 expenses pursuant to s. 112.061.
157 (4) Persons who derive their income from resources
158 controlled by the department or the agency are ineligible for
159 membership on the board.
160 (5) Subject to and consistent with direction set by the
161 Legislature, the board shall exercise the following
162 responsibilities:
163 (a) Request and review the collection and analysis of
164 needs assessment data as described in s. 394.82.
165 (b) Review the status of publicly funded mental health and
166 substance abuse systems and recommend to the secretary of the
167 department and the secretary of the agency policy designed to
168 improve coordination and effectiveness.

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169 (c) Provide mechanisms for substance abuse and mental
170 health stakeholders, including consumers, family members,
171 providers, and advocates, to provide input concerning the
172 management of the system.
173 (d) Recommend priorities for service expansion to the
174 department and the agency.
175 (e) Prepare a proposed behavioral health legislative
176 budget request and submit the budget request to the secretary
177 with a copy to the Governor, the President of the Senate, and
178 the Speaker of the House of Representatives. The secretary
179 shall submit the department's legislative budget request to the
180 Governor in accordance with s. 216.023.
181 (f) Review performance data prepared by the department and
182 the agency.
183 (g) Make policy recommendations to the secretary of the
184 department and the secretary of the agency concerning strategies
185 for improving the performance of the system.
186 (h) Review and forecast substance abuse and mental health
187 staffing needs and recommend to the secretary of the department
188 and the Commissioner of Education policies that continuously
189 improve the quality and availability of staff.
190 (6) The board shall work with the department and the
191 agency to ensure, to the maximum extent possible, that Medicaid
192 and department-funded services are delivered in a coordinated
193 manner using common service definitions, standards, and
194 accountability mechanisms.

195 (7) The memorandum shall include a description of how the
196 department will support the board and respond to its requests
197 for information.
198 (8) The board must annually evaluate and, in December of
199 each year, report to the Legislature and the Governor on the
200 status of the state's publicly-funded substance abuse and mental
201 health systems. The board's first report must be submitted in
202 December 2004. Each public sector agency that delivers, or
203 contracts for the provision of, substance abuse or mental health
204 services must cooperate with the board in the development of
205 this annual evaluation and report.
206 (9) This section shall expire on October 1, 2006, unless
207 reviewed and reenacted by the Legislature before that date. The
208 Office of Program Policy Analysis and Government Accountability
209 and the Auditor General shall conduct an independent evaluation
210 of the effectiveness of the substance abuse and mental health
211 programs. The evaluation must include, but need not be limited
212 to, the operation of the board and the organization of programs
213 within the department. A report that includes recommendations
214 relating to the continuation of the board and the organizational
215 arrangement of the programs must be submitted by the Executive
216 Office of the Governor to the President of the Senate and the
217 Speaker of the House of Representatives by January 1, 2006.
218 Section 3. Subsections (1) and (2) of section 409.912,
219 Florida Statutes, are renumbered as subsections (2) and (3),
220 respectively, subsection (3) is renumbered as subsection (4) and
221 paragraphs (b) and (c) of said subsection are amended,
222 subsection (19) is renumbered as subsection (21) and paragraph

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223 (c) of said subsection is amended, subsection (27) is renumbered
224 as subsection (29) and amended, present subsections (4) through
225 (18) are renumbered as subsections (6) through (20),
226 respectively, present subsections (20) through (26) are
227 renumbered as subsections (22) through (28), respectively,
228 present subsections (28) through (40) are renumbered as
229 subsections (30) through (42), respectively, and new subsections
230 (1) and (5) are added to said section, to read:
231 409.912 Cost-effective purchasing of health care.--The
232 agency shall purchase goods and services for Medicaid recipients
233 in the most cost-effective manner consistent with the delivery
234 of quality medical care. The agency shall maximize the use of
235 prepaid per capita and prepaid aggregate fixed-sum basis
236 services when appropriate and other alternative service delivery
237 and reimbursement methodologies, including competitive bidding
238 pursuant to s. 287.057, designed to facilitate the cost-
239 effective purchase of a case-managed continuum of care. The
240 agency shall also require providers to minimize the exposure of
241 recipients to the need for acute inpatient, custodial, and other
242 institutional care and the inappropriate or unnecessary use of
243 high-cost services. The agency may establish prior authorization
244 requirements for certain populations of Medicaid beneficiaries,
245 certain drug classes, or particular drugs to prevent fraud,
246 abuse, overuse, and possible dangerous drug interactions. The
247 Pharmaceutical and Therapeutics Committee shall make
248 recommendations to the agency on drugs for which prior
249 authorization is required. The agency shall inform the

250 Pharmaceutical and Therapeutics Committee of its decisions
251 regarding drugs subject to prior authorization.
252 (1) The agency shall work with the Department of Children
253 and Family Services to ensure access of children and families in
254 the child protection system to needed and appropriate mental
255 health and substance abuse services.
256 (4)~~(3)~~ The agency may contract with:
257 (b) An entity that is providing comprehensive behavioral
258 health care services to certain Medicaid recipients through a
259 capitated, prepaid arrangement pursuant to the federal waiver
260 provided for by s. 409.905(5). Such an entity must be licensed
261 under chapter 624, chapter 636, or chapter 641 and must possess
262 the clinical systems and operational competence to manage risk
263 and provide comprehensive behavioral health care to Medicaid
264 recipients. As used in this paragraph, the term "comprehensive
265 behavioral health care services" means covered mental health and
266 substance abuse treatment services that are available to
267 Medicaid recipients. The Secretary of the Department of Children
268 and Family Services shall approve provisions of procurements
269 related to children in the department's care or custody prior to
270 enrolling such children in a prepaid behavioral health plan. Any
271 contract awarded under this paragraph must be competitively
272 procured. In developing the behavioral health care prepaid plan
273 procurement document, the agency shall ensure that the
274 procurement document requires the contractor to develop and
275 implement a plan to ensure compliance with s. 394.4574 related
276 to services provided to residents of licensed assisted living
277 facilities that hold a limited mental health license. The

278 agency shall seek federal approval to contract with a single
279 entity meeting these requirements to provide comprehensive
280 behavioral health care services to all Medicaid recipients in a
281 group of districts or counties. Each entity must offer
282 sufficient choices of providers in its network to ensure
283 recipient access to care and the opportunity to select a
284 provider with whom the recipient is satisfied. ~~The agency must~~
285 ~~ensure that Medicaid recipients have available the choice of at~~
286 ~~least two managed care plans for their behavioral health care~~
287 ~~services.~~ To ensure unimpaired access to behavioral health care
288 services by Medicaid recipients, all contracts issued pursuant
289 to this paragraph shall require 80 percent of the capitation
290 paid to the managed care plan, including health maintenance
291 organizations, to be expended for the provision of behavioral
292 health care services. In the event the managed care plan expends
293 less than 80 percent of the capitation paid pursuant to this
294 paragraph for the provision of behavioral health care services,
295 the difference shall be returned to the agency. The agency shall
296 provide the managed care plan with a certification letter
297 indicating the amount of capitation paid during each calendar
298 year for the provision of behavioral health care services
299 pursuant to this section. The agency may reimburse for
300 substance-abuse-treatment services on a fee-for-service basis
301 until the agency finds that adequate funds are available for
302 capitated, prepaid arrangements.
303 1. By January 1, 2001, the agency shall modify the
304 contracts with the entities providing comprehensive inpatient
305 and outpatient mental health care services to Medicaid

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306 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
307 Counties, to include substance-abuse-treatment services.
308 2. By July 1, 2003, the agency and the Department of
309 Children and Family Services shall execute a written agreement
310 that requires collaboration and joint development of all
311 policies, budgets, procurement documents, contracts, and
312 monitoring plans that have an impact on the state and Medicaid
313 community mental health and targeted case management programs.
314 3. By July 1, 2006, the agency shall contract with managed
315 care entities in each AHCA area except area 6 to provide
316 comprehensive inpatient and outpatient mental health and
317 substance abuse services through capitated prepaid arrangements
318 to all Medicaid recipients for whom such plans are allowable
319 under federal law and regulation. In AHCA areas where eligible
320 individuals number less than 150,000, the agency shall contract
321 with a single managed care plan. The agency shall contract with
322 more than one plan in AHCA areas where the eligible population
323 exceeds 150,000. Contracts awarded pursuant to this section
324 shall be competitively procured. For profit and not-for-profit
325 corporations shall be eligible to compete.
326 4. By January 1, 2004, the agency and the department shall
327 submit a plan to the Governor, the President of the Senate, and
328 the Speaker of the House of Representatives for review and
329 approval that provides for the full implementation of capitated
330 prepaid behavioral health care in all areas of the state.
331
332 The plan shall include provisions which ensure that children and
333 families receiving foster care and other related services are

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334 appropriately served and that these services assist the
335 community-based care lead agencies in meeting the goals and
336 outcomes of the child welfare system. The plan shall be
337 developed with the participation of community-based care lead
338 agencies, community alliances, sheriffs, and community providers
339 serving dependent children.
340 ~~2. By December 31, 2001, the agency shall contract with~~
341 ~~entities providing comprehensive behavioral health care services~~
342 ~~to Medicaid recipients through capitated, prepaid arrangements~~
343 ~~in Charlotte, Collier, DeSoto, Escambia, Glades, Hendry, Lee,~~
344 ~~Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota, and Walton~~
345 ~~Counties. The agency may contract with entities providing~~
346 ~~comprehensive behavioral health care services to Medicaid~~
347 ~~recipients through capitated, prepaid arrangements in Alachua~~
348 ~~County. The agency may determine if Sarasota County shall be~~
349 ~~included as a separate catchment area or included in any other~~
350 ~~agency geographic area.~~
351 4.~~3.~~ Children residing in a Department of Juvenile Justice
352 or Department of Children and Family Services residential
353 program approved as a Medicaid behavioral health overlay
354 services provider shall not be included in a behavioral health
355 care prepaid health plan pursuant to this paragraph.
356 5.~~4.~~ In converting to a prepaid system of delivery, the
357 agency shall in its procurement document require an entity
358 providing comprehensive behavioral health care services to
359 prevent the displacement of indigent care patients by enrollees
360 in the Medicaid prepaid health plan providing behavioral health
361 care services from facilities receiving state funding to provide

362 indigent behavioral health care, to facilities licensed under
363 chapter 395 which do not receive state funding for indigent
364 behavioral health care, or reimburse the unsubsidized facility
365 for the cost of behavioral health care provided to the displaced
366 indigent care patient.
367 6.~~5.~~ Traditional community mental health providers under
368 contract with the Department of Children and Family Services
369 pursuant to part IV of chapter 394, child welfare providers
370 under contract with the Department of Children and Family
371 Services, and inpatient mental health providers licensed
372 pursuant to chapter 395 must be offered an opportunity to accept
373 or decline a contract to participate in any provider network for
374 prepaid behavioral health services.
375 (c) A federally qualified health center or an entity owned
376 by one or more federally qualified health centers or an entity
377 owned by other migrant and community health centers receiving
378 non-Medicaid financial support from the Federal Government to
379 provide health care services on a prepaid or fixed-sum basis to
380 recipients. Such prepaid health care services entity must be
381 licensed under parts I and III of chapter 641, but shall be
382 prohibited from serving Medicaid recipients on a prepaid basis,
383 until such licensure has been obtained. However, such an entity
384 is exempt from s. 641.225 if the entity meets the requirements
385 specified in subsections (16)~~(14)~~ and (17)~~(15)~~.
386 (5) By October 1, 2003, the agency and the department
387 shall, to the extent feasible, develop a plan for implementing
388 new Medicaid procedure codes for emergency and crisis care,
389 supportive residential services, and other services designed to

390 maximize the use of Medicaid funds for Medicaid-eligible
391 recipients. The agency shall include in the agreement developed
392 pursuant to subsection (4), a provision that ensures that the
393 match requirements for these new procedure codes are met by
394 certifying eligible general revenue or local funds that are
395 currently expended on these services by the department with
396 contracted alcohol, drug abuse, and mental health providers.
397 The plan must describe specific procedure codes to be
398 implemented, a projection of the number of procedures to be
399 delivered during fiscal year 2003-2004, and a financial analysis
400 which describes the certified match procedures and
401 accountability mechanisms, projects the earnings associated with
402 these procedures, and describes the sources of state match.
403 This plan shall not be implemented in any part until approved by
404 the Legislative Budget Commission. If such approval has not
405 occurred by December 31, 2003, the plan shall be submitted for
406 consideration by the 2004 Legislature.
407 (21)~~(19)~~ Any entity contracting with the agency pursuant
408 to this section to provide health care services to Medicaid
409 recipients is prohibited from engaging in any of the following
410 practices or activities:
411 (c) Granting or offering of any monetary or other valuable
412 consideration for enrollment, except as authorized by subsection
413 (23)~~(21)~~.
414 (29)~~(27)~~ The agency shall perform enrollments and
415 disenrollments for Medicaid recipients who are eligible for
416 MediPass or managed care plans. Notwithstanding the prohibition
417 contained in paragraph (20)~~(18)~~(f), managed care plans may

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418 perform preenrollments of Medicaid recipients under the
419 supervision of the agency or its agents. For the purposes of
420 this section, "preenrollment" means the provision of marketing
421 and educational materials to a Medicaid recipient and assistance
422 in completing the application forms, but shall not include
423 actual enrollment into a managed care plan. An application for
424 enrollment shall not be deemed complete until the agency or its
425 agent verifies that the recipient made an informed, voluntary
426 choice. The agency, in cooperation with the Department of
427 Children and Family Services, may test new marketing initiatives
428 to inform Medicaid recipients about their managed care options
429 at selected sites. The agency shall report to the Legislature on
430 the effectiveness of such initiatives. The agency may contract
431 with a third party to perform managed care plan and MediPass
432 enrollment and disenrollment services for Medicaid recipients
433 and is authorized to adopt rules to implement such services. The
434 agency may adjust the capitation rate only to cover the costs of
435 a third-party enrollment and disenrollment contract, and for
436 agency supervision and management of the managed care plan
437 enrollment and disenrollment contract.
438 Section 4. Subsection (6) of section 394.741, Florida
439 Statutes, is amended, new subsections (7) and (8) are added to
440 said section, and present subsections (7) and (8) are renumbered
441 as subsections (9) and (10), respectively, to read:
442 394.741 Accreditation requirements for providers of
443 behavioral health care services.--
444 (6) The department or agency, by accepting the survey or
445 inspection of an accrediting organization, does not forfeit its

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446 rights to monitor for the purpose of ensuring that services for
447 which the department has paid are provided. The department is
448 authorized to investigate complaints or suspected problems and
449 to monitor the provider's compliance with negotiated terms and
450 conditions, including provisions relating to consent decrees
451 that are unique to a specific contract and are not statements of
452 general applicability. The department may monitor compliance
453 with federal and state statutes, federal regulations, or state
454 administrative rules, provided such monitoring does not
455 duplicate the review of accreditation standards or independent
456 audits pursuant to subsections (3) and (8) ~~to perform~~
457 ~~inspections at any time, including contract monitoring to ensure~~
458 ~~that deliverables are provided in accordance with the contract~~.
459 (7) For the purposes of licensure and monitoring of
460 facilities under contract with the department, the department
461 shall rely only upon properly adopted and applicable federal and
462 state statutes and rules.
463 (8) The department shall file a State Projects Compliance
464 Supplement pursuant to s. 215.97 for behavioral health care
465 services. In monitoring the financial operations of its
466 contractors, the department shall rely upon certified public
467 accountant audits, if required. The department shall perform a
468 desk review of its contractors' most recent independent audit
469 and may conduct onsite monitoring only of problems identified by
470 these audits, or by other sources of information documenting
471 problems with contractors' financial management. Certified
472 public accountants employed by the department may conduct an on-

473 site test of the validity of a contractor's independent audit
474 every third year.
475 (9)~~(7)~~ The department and the agency shall report to the
476 Legislature by January 1, 2003, on the viability of mandating
477 all organizations under contract with the department for the
478 provision of behavioral health care services, or licensed by the
479 agency or department to be accredited. The department and the
480 agency shall also report to the Legislature by January 1, 2003,
481 on the viability of privatizing all licensure and monitoring
482 functions through an accrediting organization.
483 (10)~~(8)~~ The accreditation requirements of this section
484 shall apply to contracted organizations that are already
485 accredited immediately upon becoming law.
486 Section 5. Paragraphs (a), (b), and (e) of subsection (4)
487 and subsection (5) of section 394.9082, Florida Statutes, are
488 amended to read:
489 394.9082 Behavioral health service delivery strategies.--
490 (4) CONTRACT FOR SERVICES.--
491 (a) The Department of Children and Family Services and the
492 Agency for Health Care Administration may contract for the
493 provision or management of behavioral health services with a
494 managing entity in at least two geographic areas. Both the
495 Department of Children and Family Services and the Agency for
496 Health Care Administration must contract with the same managing
497 entity in any distinct geographic area where the strategy
498 operates. This managing entity shall be accountable for the
499 delivery of behavioral health services specified by the
500 department and the agency for children, adolescents, and adults.

501 The geographic area must be of sufficient size in population and
502 have enough public funds for behavioral health services to allow
503 for flexibility and maximum efficiency. Notwithstanding the
504 provisions of s. 409.912(4)~~(3)~~(b)1. ~~and 2.~~, at least one service
505 delivery strategy must be in one of the service districts in the
506 catchment area of G. Pierce Wood Memorial Hospital.
507 (b) Under one of the service delivery strategies, the
508 Department of Children and Family Services may contract with a
509 prepaid mental health plan that operates under s. 409.912 to be
510 the managing entity. Under this strategy, the Department of
511 Children and Family Services is not required to competitively
512 procure those services and, notwithstanding other provisions of
513 law, may employ prospective payment methodologies that the
514 department finds are necessary to improve client care or
515 institute more efficient practices. The Department of Children
516 and Family Services may employ in its contract any provision of
517 the current prepaid behavioral health care plan authorized under
518 s. 409.912(4)~~(3)~~(a) and (b), or any other provision necessary to
519 improve quality, access, continuity, and price. Any contracts
520 under this strategy in Area 6 of the Agency for Health Care
521 Administration or in the prototype region under s. 20.19(7) of
522 the Department of Children and Family Services may be entered
523 with the existing substance abuse treatment provider network if
524 an administrative services organization is part of its network.
525 In Area 6 of the Agency for Health Care Administration or in the
526 prototype region of the Department of Children and Family
527 Services, the Department of Children and Family Services and the
528 Agency for Health Care Administration may employ alternative

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529 service delivery and financing methodologies, which may include
530 prospective payment for certain population groups. The
531 population groups that are to be provided these substance abuse
532 services would include at a minimum: individuals and families
533 receiving family safety services; Medicaid-eligible children,
534 adolescents, and adults who are substance-abuse-impaired; or
535 current recipients and persons at risk of needing cash
536 assistance under Florida's welfare reform initiatives.
537 (e) The cost of the managing entity contract shall be
538 funded through a combination of funds from the Department of
539 Children and Family Services and the Agency for Health Care
540 Administration. To operate the managing entity, the Department
541 of Children and Family Services and the Agency for Health Care
542 Administration may not expend more than 10 percent of the annual
543 appropriations for mental health and substance abuse treatment
544 services prorated to the geographic areas and must include all
545 behavioral health Medicaid funds, including psychiatric
546 inpatient funds. This restriction does not apply to a prepaid
547 behavioral health plan that is authorized under s.
548 409.912<u>(4)</u>~~(3)~~(a) and(b).
549 (5) STATEWIDE ACTIONS.--~~If Medicaid appropriations for~~
550 ~~Community Mental Health Services or Mental Health Targeted Case~~
551 ~~Management are reduced in fiscal year 2001-2002,~~ The agency and
552 the department shall jointly develop and implement strategies
553 that reduce service costs in a manner that mitigates the impact
554 on persons in need of those services. The agency and department
555 may employ any methodologies on a regional or statewide basis
556 necessary to achieve the reduction, including but not limited to

557 use of case rates, prepaid per capita contracts, utilization
558 management, expanded use of care management, use of waivers from
559 the Centers for Medicare and Medicaid Services ~~Health Care~~
560 ~~Financing Administration~~ to maximize federal matching of current
561 local and state funding, modification or creation of additional
562 procedure codes, and certification of match or other management
563 techniques. The department may contract with a single managing
564 entity or provider network that shall be responsible for
565 delivering state-funded mental health services. The managing
566 entity shall coordinate its delivery of mental health and
567 substance abuse services with all prepaid mental health plans in
568 the region or the district. The department may include in its
569 contract with the managing entity data management and data
570 reporting requirements, and clinical, program management, and
571 administrative functions. Before the department contracts for
572 these functions with the provider network, the department shall
573 determine that the entity has the capacity and capability to
574 assume these functions. The roles and responsibilities of each
575 party must be clearly delineated in the contract.
576 Section 6. Subsection (2) of section 636.066, Florida
577 Statutes, is amended to read:
578 636.066 Taxes imposed.--
579 (2) Beginning January 1, 1994, the tax shall be imposed on
580 all premiums, contributions, and assessments for limited health
581 services. Payments made to a prepaid limited health services
582 organization by the Agency for Health Care Administration under
583 a contract entered into pursuant to s. 409.912(4)(b) for
584 comprehensive behavioral health care services that specifies a

585 minimum loss ratio do not constitute premiums, contributions, or
586 assessments for limited health services and are not subject to
587 the premium tax under s. 624.509. The Agency for Health Care
588 Administration shall provide the prepaid limited health services
589 organization with a certification letter indicating the amount
590 of premiums, capitation, and assessments it has paid during each
591 calendar year for such comprehensive behavioral health services.
592 Section 7. Subsection (4) of section 409.908, Florida
593 Statutes, is amended to read:
594 409.908 Reimbursement of Medicaid providers.--Subject to
595 specific appropriations, the agency shall reimburse Medicaid
596 providers, in accordance with state and federal law, according
597 to methodologies set forth in the rules of the agency and in
598 policy manuals and handbooks incorporated by reference therein.
599 These methodologies may include fee schedules, reimbursement
600 methods based on cost reporting, negotiated fees, competitive
601 bidding pursuant to s. 287.057, and other mechanisms the agency
602 considers efficient and effective for purchasing services or
603 goods on behalf of recipients. If a provider is reimbursed based
604 on cost reporting and submits a cost report late and that cost
605 report would have been used to set a lower reimbursement rate
606 for a rate semester, then the provider's rate for that semester
607 shall be retroactively calculated using the new cost report, and
608 full payment at the recalculated rate shall be affected
609 retroactively. Medicare-granted extensions for filing cost
610 reports, if applicable, shall also apply to Medicaid cost
611 reports. Payment for Medicaid compensable services made on
612 behalf of Medicaid eligible persons is subject to the

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613 availability of moneys and any limitations or directions
614 provided for in the General Appropriations Act or chapter 216.
615 Further, nothing in this section shall be construed to prevent
616 or limit the agency from adjusting fees, reimbursement rates,
617 lengths of stay, number of visits, or number of services, or
618 making any other adjustments necessary to comply with the
619 availability of moneys and any limitations or directions
620 provided for in the General Appropriations Act, provided the
621 adjustment is consistent with legislative intent.
622 (4) Subject to any limitations or directions provided for
623 in the General Appropriations Act, alternative health plans,
624 health maintenance organizations, and prepaid health plans shall
625 be reimbursed a fixed, prepaid amount negotiated, or
626 competitively bid pursuant to s. 287.057, by the agency and
627 prospectively paid to the provider monthly for each Medicaid
628 recipient enrolled. The amount may not exceed the average amount
629 the agency determines it would have paid, based on claims
630 experience, for recipients in the same or similar category of
631 eligibility. The agency shall calculate capitation rates on a
632 regional basis and, beginning September 1, 1995, shall include
633 age-band differentials in such calculations. Effective July 1,
634 2001, the cost of exempting statutory teaching hospitals,
635 specialty hospitals, and community hospital education program
636 hospitals from reimbursement ceilings and the cost of special
637 Medicaid payments shall not be included in premiums paid to
638 health maintenance organizations or prepaid health care plans.
639 Each rate semester, the agency shall calculate and publish a
640 Medicaid hospital rate schedule that does not reflect either

641 special Medicaid payments or the elimination of rate
642 reimbursement ceilings, to be used by hospitals and Medicaid
643 health maintenance organizations, in order to determine the
644 Medicaid rate referred to in ss. 409.912(19)~~(17)~~, 409.9128(5),
645 and 641.513(6).
646 Section 8. Subsections (1) and (2) of section 409.91196,
647 Florida Statutes, are amended to read:
648 409.91196 Supplemental rebate agreements; confidentiality
649 of records and meetings.--
650 (1) Trade secrets, rebate amount, percent of rebate,
651 manufacturer's pricing, and supplemental rebates which are
652 contained in records of the Agency for Health Care
653 Administration and its agents with respect to supplemental
654 rebate negotiations and which are prepared pursuant to a
655 supplemental rebate agreement under s. 409.912(39)~~(37)~~(a)7. are
656 confidential and exempt from s. 119.07 and s. 24(a), Art. I of
657 the State Constitution.
658 (2) Those portions of meetings of the Medicaid
659 Pharmaceutical and Therapeutics Committee at which trade
660 secrets, rebate amount, percent of rebate, manufacturer's
661 pricing, and supplemental rebates are disclosed for discussion
662 or negotiation of a supplemental rebate agreement under s.
663 409.912(39)~~(37)~~(a)7. are exempt from s. 286.011 and s. 24(b),
664 Art. I of the State Constitution.
665 Section 9. Paragraph (f) of subsection (2) of section
666 409.9122, Florida Statutes, is amended to read:
667 409.9122 Mandatory Medicaid managed care enrollment;
668 programs and procedures.--

669 (2)
670 (f) When a Medicaid recipient does not choose a managed
671 care plan or MediPass provider, the agency shall assign the
672 Medicaid recipient to a managed care plan or MediPass provider.
673 Medicaid recipients who are subject to mandatory assignment but
674 who fail to make a choice shall be assigned to managed care
675 plans until an enrollment of 45 percent in MediPass and 55
676 percent in managed care plans is achieved. Once this enrollment
677 is achieved, the assignments shall be divided in order to
678 maintain an enrollment in MediPass and managed care plans which
679 is in a 45 percent and 55 percent proportion, respectively.
680 Thereafter, assignment of Medicaid recipients who fail to make a
681 choice shall be based proportionally on the preferences of
682 recipients who have made a choice in the previous period. Such
683 proportions shall be revised at least quarterly to reflect an
684 update of the preferences of Medicaid recipients. The agency
685 shall disproportionately assign Medicaid-eligible recipients who
686 are required to but have failed to make a choice of managed care
687 plan or MediPass, including children, and who are to be assigned
688 to the MediPass program to children's networks as described in
689 s. 409.912(4)~~(3)~~(g), Children's Medical Services network as
690 defined in s. 391.021, exclusive provider organizations,
691 provider service networks, minority physician networks, and
692 pediatric emergency department diversion programs authorized by
693 this chapter or the General Appropriations Act, in such manner
694 as the agency deems appropriate, until the agency has determined
695 that the networks and programs have sufficient numbers to be
696 economically operated. For purposes of this paragraph, when

697 referring to assignment, the term "managed care plans" includes
698 health maintenance organizations, exclusive provider
699 organizations, provider service networks, minority physician
700 networks, Children's Medical Services network, and pediatric
701 emergency department diversion programs authorized by this
702 chapter or the General Appropriations Act. Beginning July 1,
703 2002, the agency shall assign all children in families who have
704 not made a choice of a managed care plan or MediPass in the
705 required timeframe to a pediatric emergency room diversion
706 program described in s. 409.912(4)~~(3)~~(g) that, as of July 1,
707 2002, has executed a contract with the agency, until such
708 network or program has reached an enrollment of 15,000 children.
709 Once that minimum enrollment level has been reached, the agency
710 shall assign children who have not chosen a managed care plan or
711 MediPass to the network or program in a manner that maintains
712 the minimum enrollment in the network or program at not less
713 than 15,000 children. To the extent practicable, the agency
714 shall also assign all eligible children in the same family to
715 such network or program. When making assignments, the agency
716 shall take into account the following criteria:
717 1. A managed care plan has sufficient network capacity to
718 meet the need of members.
719 2. The managed care plan or MediPass has previously
720 enrolled the recipient as a member, or one of the managed care
721 plan's primary care providers or MediPass providers has
722 previously provided health care to the recipient.
723 3. The agency has knowledge that the member has previously
724 expressed a preference for a particular managed care plan or

725 MediPass provider as indicated by Medicaid fee-for-service
726 claims data, but has failed to make a choice.
727 4. The managed care plan's or MediPass primary care
728 providers are geographically accessible to the recipient's
729 residence.
730 Section 10. Section 636.0145, Florida Statutes, is amended
731 to read:
732 636.0145 Certain entities contracting with Medicaid.--
733 Notwithstanding the requirements of s. 409.912(4)~~(3)~~(b), an
734 entity that is providing comprehensive inpatient and outpatient
735 mental health care services to certain Medicaid recipients in
736 Hillsborough, Highlands, Hardee, Manatee, and Polk Counties
737 through a capitated, prepaid arrangement pursuant to the federal
738 waiver provided for in s. 409.905(5) must become licensed under
739 chapter 636 by December 31, 1998. Any entity licensed under this
740 chapter which provides services solely to Medicaid recipients
741 under a contract with Medicaid shall be exempt from ss. 636.017,
742 636.018, 636.022, 636.028, and 636.034.
743 Section 11. Subsection (3) of section 641.225, Florida
744 Statutes, is amended to read:
745 641.225 Surplus requirements.--
746 (3)(a) An entity providing prepaid capitated services
747 which is authorized under s. 409.912(4)~~(3)~~(a) and which applies
748 for a certificate of authority is subject to the minimum surplus
749 requirements set forth in subsection (1), unless the entity is
750 backed by the full faith and credit of the county in which it is
751 located.

752 (b) An entity providing prepaid capitated services which
753 is authorized under s. 409.912(4)~~(3)~~(b) or (c), and which
754 applies for a certificate of authority is subject to the minimum
755 surplus requirements set forth in s. 409.912.
756 Section 12. Subsection (4) of section 641.386, Florida
757 Statutes, is amended to read:
758 641.386 Agent licensing and appointment required;
759 exceptions.--
760 (4) All agents and health maintenance organizations shall
761 comply with and be subject to the applicable provisions of ss.
762 641.309 and 409.912(21)~~(19)~~, and all companies and entities
763 appointing agents shall comply with s. 626.451, when marketing
764 for any health maintenance organization licensed pursuant to
765 this part, including those organizations under contract with the
766 Agency for Health Care Administration to provide health care
767 services to Medicaid recipients or any private entity providing
768 health care services to Medicaid recipients pursuant to a
769 prepaid health plan contract with the Agency for Health Care
770 Administration.
771 Section 13. This act shall take effect upon becoming a
772 law.

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