

1
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 Persons with Disabilities; amending
8 a specified portion of proviso in Specific
9 Appropriation 270 in chapter 2007-72, Laws of
10 Florida; amending s. 409.908, F.S.; deleting a
11 provision providing that an operator of a
12 Medicaid nursing home may qualify for an
13 increased reimbursement rate due to a change of
14 ownership or licensed operator; providing a
15 limitation on the reimbursement rates for
16 Medicaid payments to nursing homes; amending s.
17 409.912, F.S.; providing for certain children
18 who are eligible for Medicaid and who reside
19 within a specified service area of the Agency
20 for Health Care Administration to be served
21 under a service delivery mechanism other than
22 the HomeSafeNet system; amending s. 409.9122,
23 F.S.; requiring that the agency give certain
24 providers priority with respect to the
25 assignment of enrollees under the Medicaid
26 managed prepaid health plan; deleting a
27 requirement that certain recipients of
28 comprehensive behavioral health services be
29 assigned to MediPass or a managed care plan;
30 amending s. 409.91211, F.S.; clarifying the
31 duties of the agency for implementing service

1 delivery mechanisms for certain children who
2 are eligible for Medicaid; providing effective
3 dates.

4
5 Be It Enacted by the Legislature of the State of Florida:

6
7 Section 1. Paragraph (f) of subsection (3) of section
8 393.0661, Florida Statutes, is amended to read:

9 393.0661 Home and community-based services delivery
10 system; comprehensive redesign.--The Legislature finds that
11 the home and community-based services delivery system for
12 persons with developmental disabilities and the availability
13 of appropriated funds are two of the critical elements in
14 making services available. Therefore, it is the intent of the
15 Legislature that the Agency for Persons with Disabilities
16 shall develop and implement a comprehensive redesign of the
17 system.

18 (3) The Agency for Health Care Administration, in
19 consultation with the agency, shall seek federal approval and
20 implement a four-tiered waiver system to serve clients with
21 developmental disabilities in the developmental disabilities
22 and family and supported living waivers. The agency shall
23 assign all clients receiving services through the
24 developmental disabilities waiver to a tier based on a valid
25 assessment instrument, client characteristics, and other
26 appropriate assessment methods. All services covered under the
27 current developmental disabilities waiver shall be available
28 to all clients in all tiers where appropriate, except as
29 otherwise provided in this subsection or in the General
30 Appropriations Act.

31

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

4 1. Supported living coaching services shall not exceed
5 20 hours per month for persons who also receive in-home
6 support services.

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

10 3. Personal care assistance services shall be limited
11 to no more than 180 hours per calendar month and shall not
12 include rate modifiers. Additional hours may be authorized for
13 persons who have intensive physical, medical, or adaptive
14 needs if such hours are essential for avoiding
15 institutionalization ~~only if a substantial change in~~
16 ~~circumstances occurs for the individual.~~

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

26 5. Chore Services, nonresidential support services,
27 and homemaker services shall be eliminated. The agency shall
28 expand the definition of in-home support services to enable
29 the provider of the service to include activities previously
30 provided in these eliminated services.

31

1 6. Massage therapy and psychological assessment
2 services shall be eliminated.

3 7. The agency shall conduct supplemental cost plan
4 reviews to verify the medical necessity of authorized services
5 for plans that have increased by more than 8 percent during
6 either of the 2 preceding fiscal years.

7 8. The agency shall implement a consolidated
8 residential habilitation rate structure to increase savings to
9 the state through a more cost-effective payment method and
10 establish uniform rates for intensive behavioral residential
11 habilitation services.

12 9. Pending federal approval, the agency is authorized
13 to extend current support plans for clients receiving services
14 under Medicaid waivers for 1 year beginning July 1, 2007, or
15 from the date approved, whichever is later. Clients who have a
16 substantial change in circumstances which threatens their
17 health and safety may be reassessed during this year in order
18 to determine the necessity for a change in their support plan.

19 Section 2. The following proviso associated with
20 Specific Appropriation 270 in chapter 2007-72, Laws of
21 Florida, is amended to read:

22 Personal Care Assistance services shall be limited to
23 no more than 180 hours per calendar month and shall not
24 include rate modifiers. Additional hours may be authorized for
25 persons who have intensive physical, medical, or adaptive
26 needs if such hours are essential for avoiding
27 institutionalization ~~only if a substantial change in~~
28 ~~circumstances occurs for the individual.~~

29 Section 3. Paragraph (b) of subsection (2) and
30 paragraph (d) of subsection (13) of section 409.908, Florida
31 Statutes, are amended to read:

1 409.908 Reimbursement of Medicaid providers.--Subject
2 to specific appropriations, the agency shall reimburse
3 Medicaid providers, in accordance with state and federal law,
4 according to methodologies set forth in the rules of the
5 agency and in policy manuals and handbooks incorporated by
6 reference therein. These methodologies may include fee
7 schedules, reimbursement methods based on cost reporting,
8 negotiated fees, competitive bidding pursuant to s. 287.057,
9 and other mechanisms the agency considers efficient and
10 effective for purchasing services or goods on behalf of
11 recipients. If a provider is reimbursed based on cost
12 reporting and submits a cost report late and that cost report
13 would have been used to set a lower reimbursement rate for a
14 rate semester, then the provider's rate for that semester
15 shall be retroactively calculated using the new cost report,
16 and full payment at the recalculated rate shall be effected
17 retroactively. Medicare-granted extensions for filing cost
18 reports, if applicable, shall also apply to Medicaid cost
19 reports. Payment for Medicaid compensable services made on
20 behalf of Medicaid eligible persons is subject to the
21 availability of moneys and any limitations or directions
22 provided for in the General Appropriations Act or chapter 216.
23 Further, nothing in this section shall be construed to prevent
24 or limit the agency from adjusting fees, reimbursement rates,
25 lengths of stay, number of visits, or number of services, or
26 making any other adjustments necessary to comply with the
27 availability of moneys and any limitations or directions
28 provided for in the General Appropriations Act, provided the
29 adjustment is consistent with legislative intent.

30 (2)
31

1 (b) Subject to any limitations or directions provided
2 for in the General Appropriations Act, the agency shall
3 establish and implement a Florida Title XIX Long-Term Care
4 Reimbursement Plan (Medicaid) for nursing home care in order
5 to provide care and services in conformance with the
6 applicable state and federal laws, rules, regulations, and
7 quality and safety standards and to ensure that individuals
8 eligible for medical assistance have reasonable geographic
9 access to such care.

10 ~~1. Changes of ownership or of licensed operator may or~~
11 ~~may not qualify for increases in reimbursement rates~~
12 ~~associated with the change of ownership or of licensed~~
13 ~~operator. The agency may amend the Title XIX Long Term Care~~
14 ~~Reimbursement Plan to provide that the initial nursing home~~
15 ~~reimbursement rates, for the operating, patient care, and MAR~~
16 ~~components, associated with related and unrelated party~~
17 ~~changes of ownership or licensed operator filed on or after~~
18 ~~September 1, 2001, are equivalent to the previous owner's~~
19 ~~reimbursement rate.~~

20 1.2. The agency shall amend the long-term care
21 reimbursement plan and cost reporting system to create direct
22 care and indirect care subcomponents of the patient care
23 component of the per diem rate. These two subcomponents
24 together shall equal the patient care component of the per
25 diem rate. Separate cost-based ceilings shall be calculated
26 for each patient care subcomponent. The direct care
27 subcomponent of the per diem rate shall be limited by the
28 cost-based class ceiling, and the indirect care subcomponent
29 may be limited by the lower of the cost-based class ceiling,
30 the target rate class ceiling, or the individual provider
31 target.

1 ~~2.3.~~ The direct care subcomponent shall include
2 salaries and benefits of direct care staff providing nursing
3 services including registered nurses, licensed practical
4 nurses, and certified nursing assistants who deliver care
5 directly to residents in the nursing home facility. This
6 excludes nursing administration, minimum data set, and care
7 plan coordinators, staff development, and staffing
8 coordinator.

9 ~~3.4.~~ All other patient care costs shall be included in
10 the indirect care cost subcomponent of the patient care per
11 diem rate. There shall be no costs directly or indirectly
12 allocated to the direct care subcomponent from a home office
13 or management company.

14 ~~4.5.~~ On July 1 of each year, the agency shall report
15 to the Legislature direct and indirect care costs, including
16 average direct and indirect care costs per resident per
17 facility and direct care and indirect care salaries and
18 benefits per category of staff member per facility.

19 ~~5.6.~~ In order to offset the cost of general and
20 professional liability insurance, the agency shall amend the
21 plan to allow for interim rate adjustments to reflect
22 increases in the cost of general or professional liability
23 insurance for nursing homes. This provision shall be
24 implemented to the extent existing appropriations are
25 available.

26
27 It is the intent of the Legislature that the reimbursement
28 plan achieve the goal of providing access to health care for
29 nursing home residents who require large amounts of care while
30 encouraging diversion services as an alternative to nursing
31 home care for residents who can be served within the

1 community. The agency shall base the establishment of any
2 maximum rate of payment, whether overall or component, on the
3 available moneys as provided for in the General Appropriations
4 Act. The agency may base the maximum rate of payment on the
5 results of scientifically valid analysis and conclusions
6 derived from objective statistical data pertinent to the
7 particular maximum rate of payment.

8 (13) Medicare premiums for persons eligible for both
9 Medicare and Medicaid coverage shall be paid at the rates
10 established by Title XVIII of the Social Security Act. For
11 Medicare services rendered to Medicaid-eligible persons,
12 Medicaid shall pay Medicare deductibles and coinsurance as
13 follows:

14 (d) Notwithstanding paragraphs (a)-(c):

15 1. Medicaid payments for Nursing Home Medicare part A
16 coinsurance shall be limited to the lesser of the Medicare
17 coinsurance amount or the Medicaid nursing home per diem rate
18 less any amounts paid by Medicare, but only up to the amount
19 of Medicare coinsurance. The Medicaid per diem rate shall be
20 the rate in effect for the dates of service of the crossover
21 claims and may not be subsequently adjusted due to subsequent
22 per diem rate adjustments.

23 2. Medicaid shall pay all deductibles and coinsurance
24 for Medicare-eligible recipients receiving freestanding end
25 stage renal dialysis center services.

26 3. Medicaid payments for general hospital inpatient
27 services shall be limited to the Medicare deductible per spell
28 of illness. Medicaid shall make no payment toward coinsurance
29 for Medicare general hospital inpatient services.

30

31

1 4. Medicaid shall pay all deductibles and coinsurance
2 for Medicare emergency transportation services provided by
3 ambulances licensed pursuant to chapter 401.

4 Section 4. Paragraph (b) of subsection (4) of section
5 409.912, Florida Statutes, is amended to read:

6 409.912 Cost-effective purchasing of health care.--The
7 agency shall purchase goods and services for Medicaid
8 recipients in the most cost-effective manner consistent with
9 the delivery of quality medical care. To ensure that medical
10 services are effectively utilized, the agency may, in any
11 case, require a confirmation or second physician's opinion of
12 the correct diagnosis for purposes of authorizing future
13 services under the Medicaid program. This section does not
14 restrict access to emergency services or poststabilization
15 care services as defined in 42 C.F.R. part 438.114. Such
16 confirmation or second opinion shall be rendered in a manner
17 approved by the agency. The agency shall maximize the use of
18 prepaid per capita and prepaid aggregate fixed-sum basis
19 services when appropriate and other alternative service
20 delivery and reimbursement methodologies, including
21 competitive bidding pursuant to s. 287.057, designed to
22 facilitate the cost-effective purchase of a case-managed
23 continuum of care. The agency shall also require providers to
24 minimize the exposure of recipients to the need for acute
25 inpatient, custodial, and other institutional care and the
26 inappropriate or unnecessary use of high-cost services. The
27 agency shall contract with a vendor to monitor and evaluate
28 the clinical practice patterns of providers in order to
29 identify trends that are outside the normal practice patterns
30 of a provider's professional peers or the national guidelines
31 of a provider's professional association. The vendor must be

1 able to provide information and counseling to a provider whose
2 practice patterns are outside the norms, in consultation with
3 the agency, to improve patient care and reduce inappropriate
4 utilization. The agency may mandate prior authorization, drug
5 therapy management, or disease management participation for
6 certain populations of Medicaid beneficiaries, certain drug
7 classes, or particular drugs to prevent fraud, abuse, overuse,
8 and possible dangerous drug interactions. The Pharmaceutical
9 and Therapeutics Committee shall make recommendations to the
10 agency on drugs for which prior authorization is required. The
11 agency shall inform the Pharmaceutical and Therapeutics
12 Committee of its decisions regarding drugs subject to prior
13 authorization. The agency is authorized to limit the entities
14 it contracts with or enrolls as Medicaid providers by
15 developing a provider network through provider credentialing.
16 The agency may competitively bid single-source-provider
17 contracts if procurement of goods or services results in
18 demonstrated cost savings to the state without limiting access
19 to care. The agency may limit its network based on the
20 assessment of beneficiary access to care, provider
21 availability, provider quality standards, time and distance
22 standards for access to care, the cultural competence of the
23 provider network, demographic characteristics of Medicaid
24 beneficiaries, practice and provider-to-beneficiary standards,
25 appointment wait times, beneficiary use of services, provider
26 turnover, provider profiling, provider licensure history,
27 previous program integrity investigations and findings, peer
28 review, provider Medicaid policy and billing compliance
29 records, clinical and medical record audits, and other
30 factors. Providers shall not be entitled to enrollment in the
31 Medicaid provider network. The agency shall determine

1 instances in which allowing Medicaid beneficiaries to purchase
2 durable medical equipment and other goods is less expensive to
3 the Medicaid program than long-term rental of the equipment or
4 goods. The agency may establish rules to facilitate purchases
5 in lieu of long-term rentals in order to protect against fraud
6 and abuse in the Medicaid program as defined in s. 409.913.
7 The agency may seek federal waivers necessary to administer
8 these policies.

9 (4) The agency may contract with:

10 (b) An entity that is providing comprehensive
11 behavioral health care services to certain Medicaid recipients
12 through a capitated, prepaid arrangement pursuant to the
13 federal waiver provided for by s. 409.905(5). Such an entity
14 must be licensed under chapter 624, chapter 636, or chapter
15 641 and must possess the clinical systems and operational
16 competence to manage risk and provide comprehensive behavioral
17 health care to Medicaid recipients. As used in this paragraph,
18 the term "comprehensive behavioral health care services" means
19 covered mental health and substance abuse treatment services
20 that are available to Medicaid recipients. The secretary of
21 the Department of Children and Family Services shall approve
22 provisions of procurements related to children in the
23 department's care or custody prior to enrolling such children
24 in a prepaid behavioral health plan. Any contract awarded
25 under this paragraph must be competitively procured. In
26 developing the behavioral health care prepaid plan procurement
27 document, the agency shall ensure that the procurement
28 document requires the contractor to develop and implement a
29 plan to ensure compliance with s. 394.4574 related to services
30 provided to residents of licensed assisted living facilities
31 that hold a limited mental health license. Except as provided

1 | in subparagraph 8., and except in counties where the Medicaid
2 | managed care pilot program is authorized pursuant to s.
3 | 409.91211, the agency shall seek federal approval to contract
4 | with a single entity meeting these requirements to provide
5 | comprehensive behavioral health care services to all Medicaid
6 | recipients not enrolled in a Medicaid managed care plan
7 | authorized under s. 409.91211 or a Medicaid health maintenance
8 | organization in an AHCA area. In an AHCA area where the
9 | Medicaid managed care pilot program is authorized pursuant to
10 | s. 409.91211 in one or more counties, the agency may procure a
11 | contract with a single entity to serve the remaining counties
12 | as an AHCA area or the remaining counties may be included with
13 | an adjacent AHCA area and shall be subject to this paragraph.
14 | Each entity must offer sufficient choice of providers in its
15 | network to ensure recipient access to care and the opportunity
16 | to select a provider with whom they are satisfied. The network
17 | shall include all public mental health hospitals. To ensure
18 | unimpaired access to behavioral health care services by
19 | Medicaid recipients, all contracts issued pursuant to this
20 | paragraph shall require 80 percent of the capitation paid to
21 | the managed care plan, including health maintenance
22 | organizations, to be expended for the provision of behavioral
23 | health care services. In the event the managed care plan
24 | expends less than 80 percent of the capitation paid pursuant
25 | to this paragraph for the provision of behavioral health care
26 | services, the difference shall be returned to the agency. The
27 | agency shall provide the managed care plan with a
28 | certification letter indicating the amount of capitation paid
29 | during each calendar year for the provision of behavioral
30 | health care services pursuant to this section. The agency may
31 | reimburse for substance abuse treatment services on a

1 fee-for-service basis until the agency finds that adequate
2 funds are available for capitated, prepaid arrangements.

3 1. By January 1, 2001, the agency shall modify the
4 contracts with the entities providing comprehensive inpatient
5 and outpatient mental health care services to Medicaid
6 recipients in Hillsborough, Highlands, Hardee, Manatee, and
7 Polk Counties, to include substance abuse treatment services.

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

14 3. Except as provided in subparagraph 8., by July 1,
15 2006, the agency and the Department of Children and Family
16 Services shall contract with managed care entities in each
17 AHCA area except area 6 or arrange to provide comprehensive
18 inpatient and outpatient mental health and substance abuse
19 services through capitated prepaid arrangements to all
20 Medicaid recipients who are eligible to participate in such
21 plans under federal law and regulation. In AHCA areas where
22 eligible individuals number less than 150,000, the agency
23 shall contract with a single managed care plan to provide
24 comprehensive behavioral health services to all recipients who
25 are not enrolled in a Medicaid health maintenance organization
26 or a Medicaid capitated managed care plan authorized under s.
27 409.91211. The agency may contract with more than one
28 comprehensive behavioral health provider to provide care to
29 recipients who are not enrolled in a Medicaid capitated
30 managed care plan authorized under s. 409.91211 or a Medicaid
31 health maintenance organization in AHCA areas where the

1 eligible population exceeds 150,000. In an AHCA area where the
2 Medicaid managed care pilot program is authorized pursuant to
3 s. 409.91211 in one or more counties, the agency may procure a
4 contract with a single entity to serve the remaining counties
5 as an AHCA area or the remaining counties may be included with
6 an adjacent AHCA area and shall be subject to this paragraph.
7 Contracts for comprehensive behavioral health providers
8 awarded pursuant to this section shall be competitively
9 procured. Both for-profit and not-for-profit corporations
10 shall be eligible to compete. Managed care plans contracting
11 with the agency under subsection (3) shall provide and receive
12 payment for the same comprehensive behavioral health benefits
13 as provided in AHCA rules, including handbooks incorporated by
14 reference. In AHCA area 11, the agency shall contract with at
15 least two comprehensive behavioral health care providers to
16 provide behavioral health care to recipients in that area who
17 are enrolled in, or assigned to, the MediPass program. One of
18 the behavioral health care contracts shall be with the
19 existing provider service network pilot project, as described
20 in paragraph (d), for the purpose of demonstrating the
21 cost-effectiveness of the provision of quality mental health
22 services through a public hospital-operated managed care
23 model. Payment shall be at an agreed-upon capitated rate to
24 ensure cost savings. Of the recipients in area 11 who are
25 assigned to MediPass under the provisions of s.
26 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled
27 recipients shall be assigned to the existing provider service
28 network in area 11 for their behavioral care.

29 4. By October 1, 2003, the agency and the department
30 shall submit a plan to the Governor, the President of the
31 Senate, and the Speaker of the House of Representatives which

1 provides for the full implementation of capitated prepaid
2 behavioral health care in all areas of the state.

3 a. Implementation shall begin in 2003 in those AHCA
4 areas of the state where the agency is able to establish
5 sufficient capitation rates.

6 b. If the agency determines that the proposed
7 capitation rate in any area is insufficient to provide
8 appropriate services, the agency may adjust the capitation
9 rate to ensure that care will be available. The agency and the
10 department may use existing general revenue to address any
11 additional required match but may not over-obligate existing
12 funds on an annualized basis.

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

18 5. Children residing in a statewide inpatient
19 psychiatric program, or in a Department of Juvenile Justice or
20 a Department of Children and Family Services residential
21 program approved as a Medicaid behavioral health overlay
22 services provider shall not be included in a behavioral health
23 care prepaid health plan or any other Medicaid managed care
24 plan pursuant to this paragraph.

25 6. In converting to a prepaid system of delivery, the
26 agency shall in its procurement document require an entity
27 providing only comprehensive behavioral health care services
28 to prevent the displacement of indigent care patients by
29 enrollees in the Medicaid prepaid health plan providing
30 behavioral health care services from facilities receiving
31 state funding to provide indigent behavioral health care, to

1 facilities licensed under chapter 395 which do not receive
2 state funding for indigent behavioral health care, or
3 reimburse the unsubsidized facility for the cost of behavioral
4 health care provided to the displaced indigent care patient.

5 7. Traditional community mental health providers under
6 contract with the Department of Children and Family Services
7 pursuant to part IV of chapter 394, child welfare providers
8 under contract with the Department of Children and Family
9 Services in areas 1 and 6, and inpatient mental health
10 providers licensed pursuant to chapter 395 must be offered an
11 opportunity to accept or decline a contract to participate in
12 any provider network for prepaid behavioral health services.

13 8. For fiscal year 2004-2005, all Medicaid eligible
14 children, except children in areas 1 and 6, whose cases are
15 open for child welfare services in the HomeSafeNet system,
16 shall be enrolled in MediPass or in Medicaid fee-for-service
17 and all their behavioral health care services including
18 inpatient, outpatient psychiatric, community mental health,
19 and case management shall be reimbursed on a fee-for-service
20 basis. Beginning July 1, 2005, such children, who are open for
21 child welfare services in the HomeSafeNet system, shall
22 receive their behavioral health care services through a
23 specialty prepaid plan operated by community-based lead
24 agencies either through a single agency or formal agreements
25 among several agencies. The specialty prepaid plan must result
26 in savings to the state comparable to savings achieved in
27 other Medicaid managed care and prepaid programs. Such plan
28 must provide mechanisms to maximize state and local revenues.
29 The specialty prepaid plan shall be developed by the agency
30 and the Department of Children and Family Services. The agency
31 is authorized to seek any federal waivers to implement this

1 initiative. Medicaid-eligible children whose cases are open
2 for child welfare services in the HomeSafeNet system and who
3 reside in AHCA area 10 are exempt from the specialty prepaid
4 plan upon the development of a service delivery mechanism for
5 children who reside in area 10 as specified in s.
6 409.91211(3)(dd).

7 Section 5. Subsection (13) of section 409.9122,
8 Florida Statutes, is amended to read:

9 409.9122 Mandatory Medicaid managed care enrollment;
10 programs and procedures.--

11 (13) Effective July 1, 2003, the agency shall adjust
12 the enrollee assignment process of Medicaid managed prepaid
13 health plans for those Medicaid managed prepaid plans
14 operating in Miami-Dade County which have executed a contract
15 with the agency for a minimum of 8 consecutive years in order
16 for the Medicaid managed prepaid plan to maintain a minimum
17 enrollment level of 15,000 members per month. When assigning
18 enrollees pursuant to this subsection, the agency shall give
19 priority to providers that initially qualified under this
20 subsection until such providers reach and maintain an
21 enrollment level of 15,000 members per month. A prepaid health
22 plan that has a statewide Medicaid enrollment of 25,000 or
23 more members is not eligible for enrollee assignments under
24 this subsection.

25 Section 6. Effective March 1, 2008, paragraph (k) of
26 subsection (2) of section 409.9122, Florida Statutes, is
27 amended to read:

28 409.9122 Mandatory Medicaid managed care enrollment;
29 programs and procedures.--

30 (2)

31

1 (k) When a Medicaid recipient does not choose a
2 managed care plan or MediPass provider, the agency shall
3 assign the Medicaid recipient to a managed care plan, except
4 in those counties in which there are fewer than two managed
5 care plans accepting Medicaid enrollees, in which case
6 assignment shall be to a managed care plan or a MediPass
7 provider. Medicaid recipients in counties with fewer than two
8 managed care plans accepting Medicaid enrollees who are
9 subject to mandatory assignment but who fail to make a choice
10 shall be assigned to managed care plans until an enrollment of
11 35 percent in MediPass and 65 percent in managed care plans,
12 of all those eligible to choose managed care, is achieved.
13 Once that enrollment is achieved, the assignments shall be
14 divided in order to maintain an enrollment in MediPass and
15 managed care plans which is in a 35 percent and 65 percent
16 proportion, respectively. ~~In service areas 1 and 6 of the~~
17 ~~Agency for Health Care Administration where the agency is~~
18 ~~contracting for the provision of comprehensive behavioral~~
19 ~~health services through a capitated prepaid arrangement,~~
20 ~~recipients who fail to make a choice shall be assigned equally~~
21 ~~to MediPass or a managed care plan.~~ For purposes of this
22 paragraph, when referring to assignment, the term "managed
23 care plans" includes exclusive provider organizations,
24 provider service networks, Children's Medical Services
25 Network, minority physician networks, and pediatric emergency
26 department diversion programs authorized by this chapter or
27 the General Appropriations Act. When making assignments, the
28 agency shall take into account the following criteria:
29 1. A managed care plan has sufficient network capacity
30 to meet the need of members.
31

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

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

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

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

15 Section 7. Paragraph (dd) of subsection (3) of section
16 409.91211, Florida Statutes, is amended to read:

17 409.91211 Medicaid managed care pilot program.--

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

21 (dd) To implement ~~develop and recommend~~ service
22 delivery mechanisms within capitated managed care plans to
23 provide Medicaid services as specified in ss. 409.905 and
24 409.906 to Medicaid-eligible children whose cases are open for
25 child welfare services in the HomeSafeNet system in foster
26 ~~care~~. These services must be coordinated with community-based
27 care providers as specified in s. 409.1671 ~~s. 409.1675~~, where
28 available, and be sufficient to meet the medical,
29 developmental, behavioral, and emotional needs of these
30 children. These service delivery mechanisms must be
31 implemented no later than July 1, 2008, in AHCA area 10 in

1 order for the children in AHCA area 10 to remain exempt from
2 the statewide plan under s. 409.912(4)(b)8.

3 Section 8. Except as otherwise expressly provided in
4 this act, this act shall take effect upon becoming a law.

5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31